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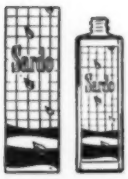

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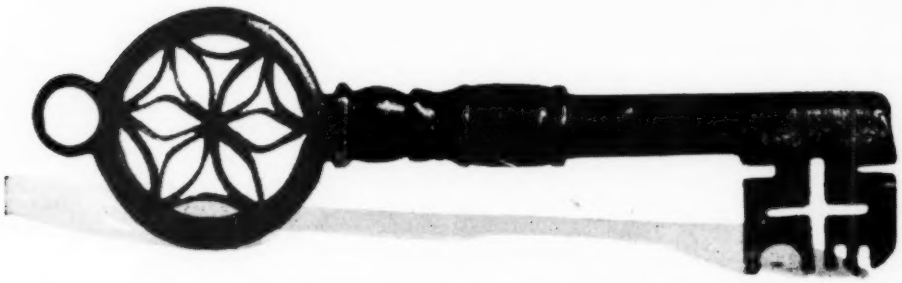

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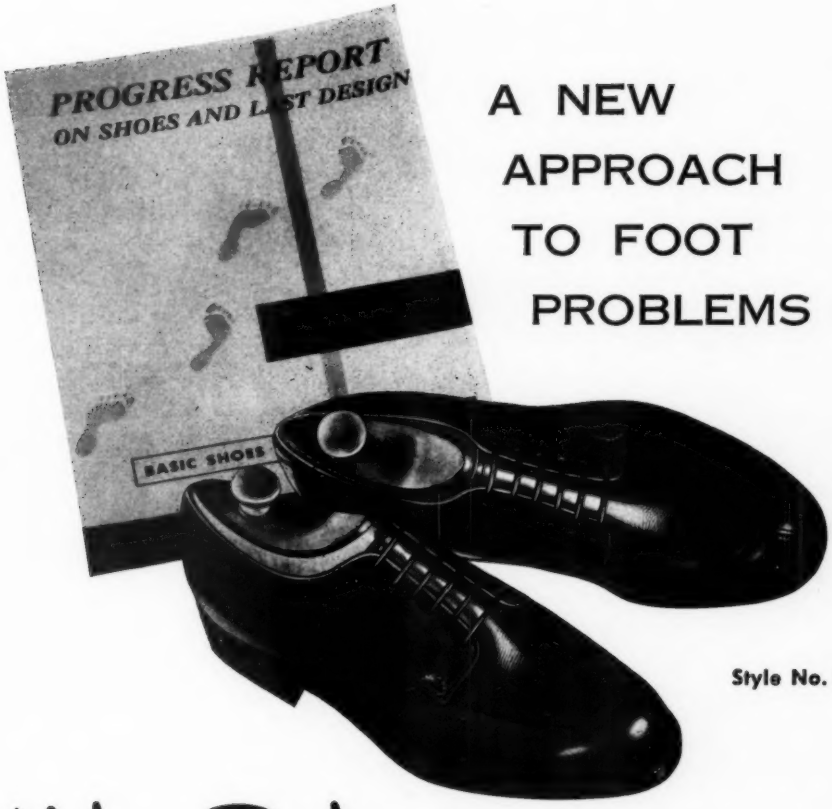

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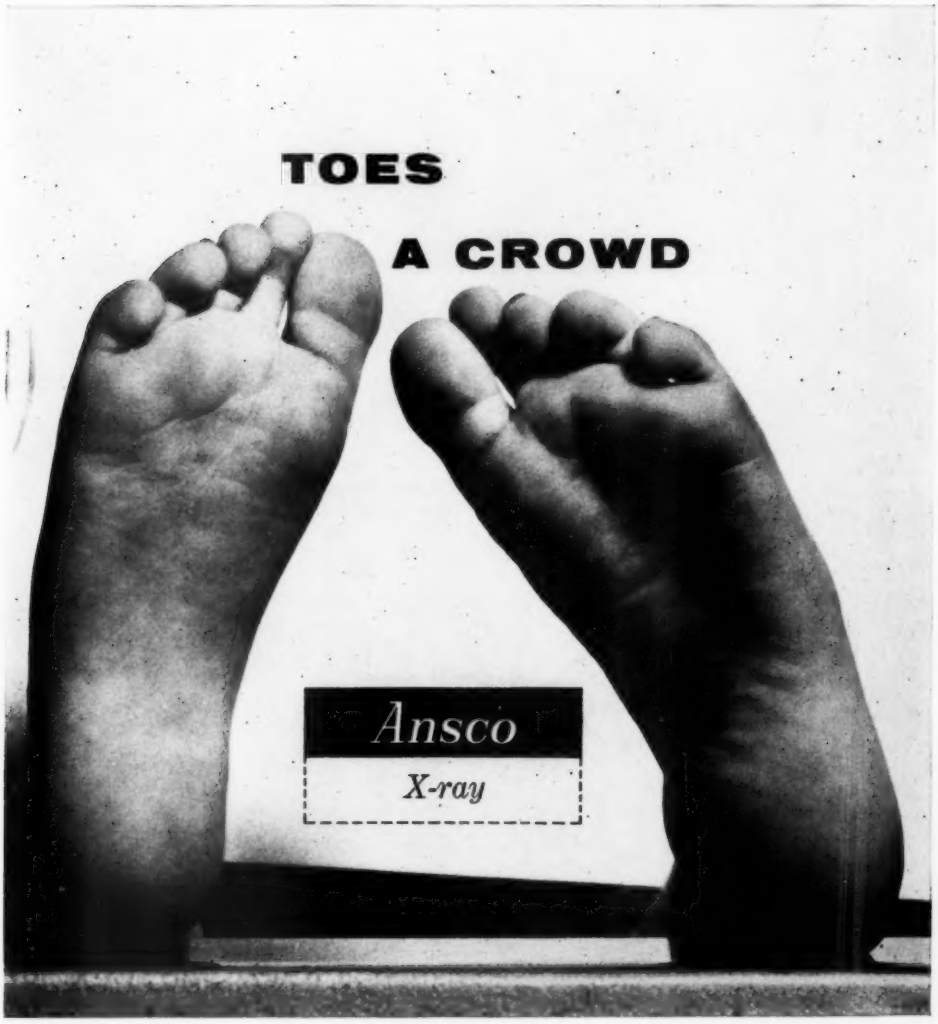

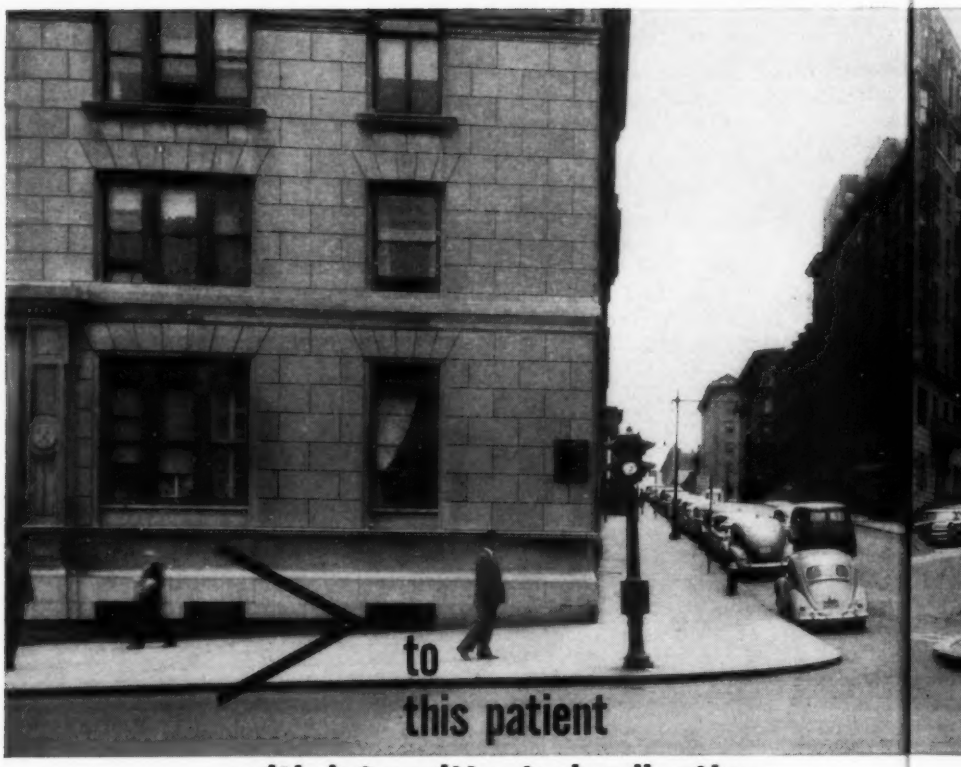

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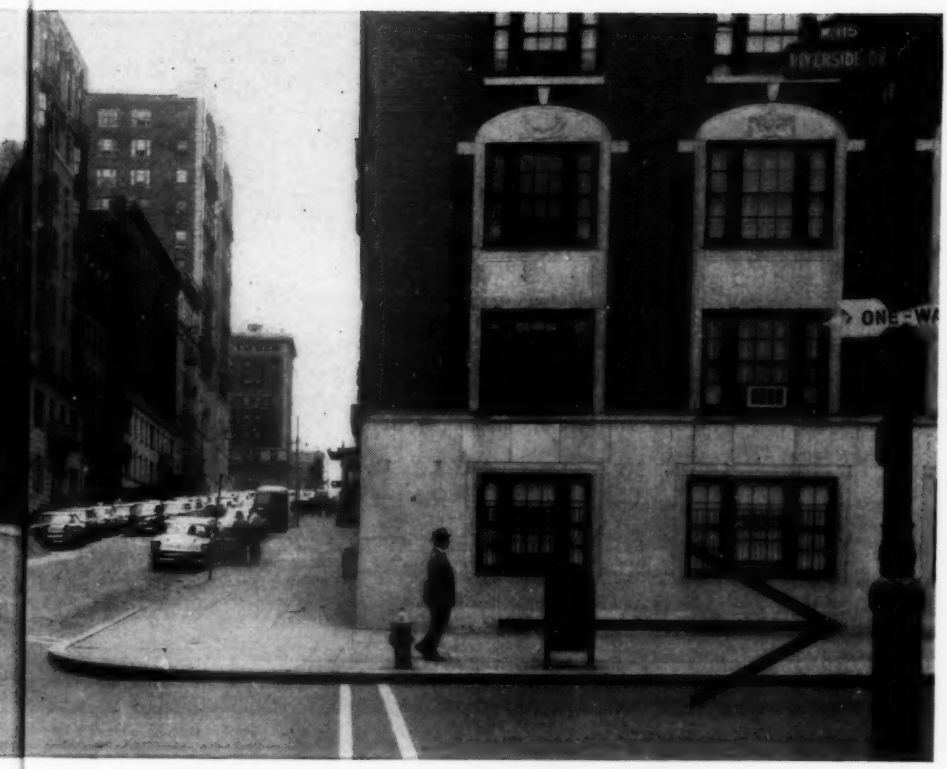

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Virginia, Podiatry Society of	I. T. Domsky, 2780 S. Randolph St., Arlington, Va.
	I. Leonard Kaplan, 718 Court St., Portsmouth, Va
Washington State Podiatry Association	R. A. Watters, 707 N. Eye St., Tacoma, Wash.
	Kurt Blau, 909 Broadway, Tacoma, Wash.
West Virginia, Chiropody Society of	Earl Sheff, 227 Morrison Bldg., Charleston, W. Va.
	G. A. Taylor, 1st Huntington Natl. Bank Bldg., Huntington, W. Va.
Wisconsin Society of Chiropodists	Eugene V. Hurtienne, 2705 North 8th St., Sheboygan, Wisc.
	Quentin E. Copeland, 324 E. Wisconsin Ave., Milwaukee, Wisc.
Wyoming Podiatry Society	J. W. Scott, 21 East Works St., Sheridan, Wyo.
	Duane NeuSchultz, 2201 West A, Torrington, Wyoming

Affiliated Organizations

Women's Auxiliary A.P.A. (N.A.C.)—Mrs. Cleotha Parham, 5328 E. 26th St., Tulsa, Okla.

Military Association of Podiatrists—Lt. John L. Charlton, Jr., D.S.C., Podiatry Clinic, Walter Reed Army Hospital, Washington, D. C.

American College of Foot Surgeons—J. M. Kohl, 3959 No. Lincoln Ave., Chicago, Ill.

American Society of Chiropodical Roentgenology—Joseph L. Starr, 1115 Main St., Bridgeport, Connecticut

Chiropody Bibliographical Research Society—S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa

American College of Foot Orthopedists—L. B. Thompson, 5613 7th Ave., Kenosha, Wisc.

American Association of Hospital Podiatrists—H. Charles Lilienfeld, 101 W. 57th St., New York, N. Y.

American Podiatry Students Association—Scott Hale, 3231 W. North 24th Place, Milwaukee, Wisc.

American Board of Chiropodical Dermatology—Joy E. Adams, Florida National Bank Bldg., St. Petersburg, Fla.

Related

Federation of Chiropody-Podiatry Boards—L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

American Association of Colleges of Chiropody—Charles E. Krausz, 926 W. Lehigh Ave., Philadelphia, Pa.

National Board of Chiropody Examiners—Pierce B. Nelson, 1770 Eddy St., San Francisco, Cal.

American Academy of Chiropodists—Mary E Lunter, 410 Goff Building, Clarksburg, W. Va.

Academy of Podiatry—Louis Lewy, 285 Madison Ave., New York, N. Y.

American Podiatry Council—L. J. Friedman, 1186 Broadway, New York, N. Y.

Fellows Pedic Research Society—Irving M. Sward, 4948 W. Dempster Rd., Skokie, Ill.

American Foot Health Foundation—Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

ACCREDITED COLLEGES

California College of Chiropody
1770 Eddy Street
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Chicago College of Chiropody
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Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
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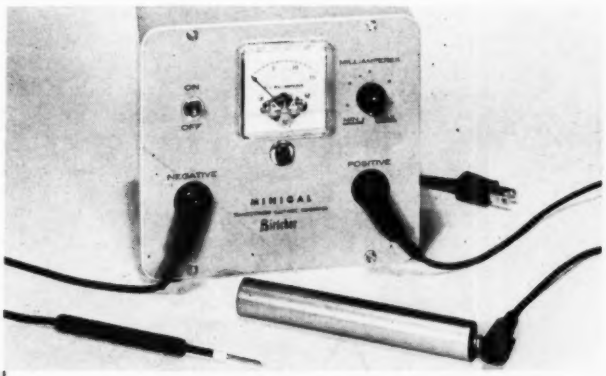

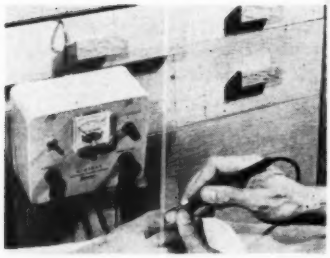

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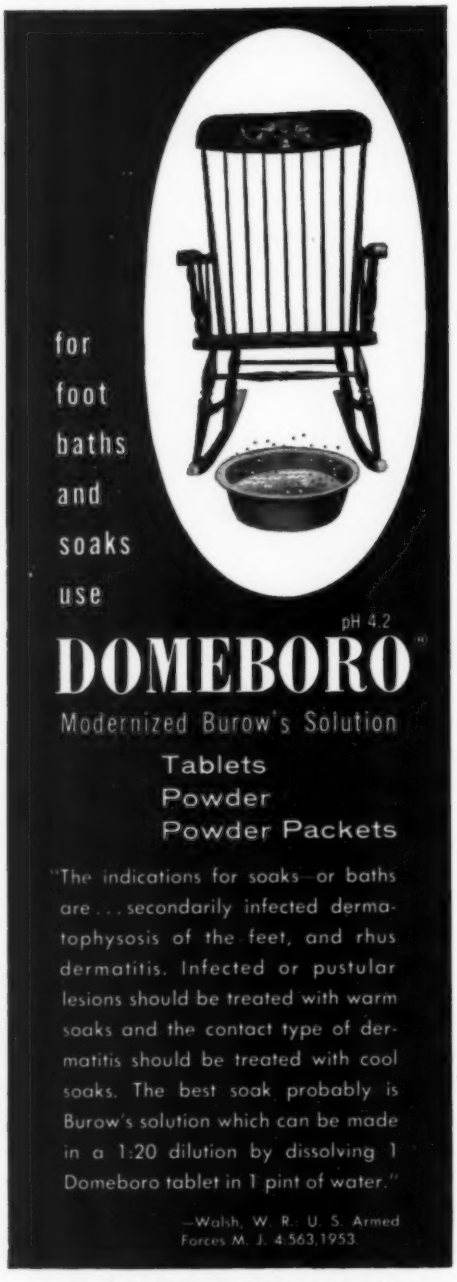
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STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

Alabama
The Alabama Medical Board of Examiners. **Board Secretary:**

Arizona
The Arizona State Board of Chiropody Examiners. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Arizona.

Arkansas
Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 800 First National Bank Bldg., Fort Smith, Ark.

California
The California Chiropody Examination Committee will meet for examination tentatively in Los Angeles, March 7-10, Aug. 22-25, 1960; in San Francisco, June 20-23; and in Sacramento, Oct. 17-20, 1960. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento, Calif.

Colorado
Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut
The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware
The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dela.

District of Columbia
The Board of Podiatry Examiners of the District of Columbia will meet for examination semi-annually in January and in July. **Board Secretary:** Harry L. Hoffman, Ph. G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida
The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia
The Georgia State Board of Podiatry Examiners will meet for reciprocity and examination in June each year, at the discretion of the Board. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho
The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois
The Illinois Chiropody Examining Committee will meet for reciprocity and examination in June 1960 at 160 No. LaSalle St., Chicago, Ill. **Superintendent of Registration:** Frederick B. Seicke, Room 109, State House, Springfield, Ill.

Indiana
The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa
The Iowa State Board of Chiropody Examiners will meet for examination in the State Office Building, Des Moines, June 13-15, 1960. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas
The Kansas State Board of Podiatry Examiners will meet for examination and reciprocity at the Kansas University Medical Center, Kansas City, Kansas, June 1960. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville, Ky.

Louisiana

Louisiana State Board of Medical Examiners will meet for examination in New Orleans, June 5-7, 1960. **Board Secretary:** C. H. Lawson, M.D., Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry will meet in March, 1960. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Robert M. Quinn, D.S.C., 16 South St., Pittsfield, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Walter J. Jeffery, 1950 Madison Ave., S.E., Grand Rapids, Michigan.

Minnesota

The Minnesota Board of Chiropody Examiners will meet for examination June 16-17, 1960. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody will meet for reciprocity and examination, April 29-30, 1960, at the Jefferson Bldg., Jefferson City, Mo. **Board Secretary:** Dr. L. A. Hansen, 500 Professional Bldg., Kansas City, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody will meet for reciprocity and examination at the State Capitol Bldg., Lincoln, Nebr., July 1960. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nevada.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N. E., Albuquerque, N. M.

New York

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STATE BOARD *(Cont.)*

North Carolina
The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota
The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio
The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma
The Oklahoma State Board of Chiropody will meet for examination when necessary, in June and September and other times as needed. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon
Oregon State Chropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 1400 S.W. Fifth Ave., Portland, Ore.

Pennsylvania
Pennsylvania State Board of Chiropody Examiners. **Board Chairman:** Dr. Ralph H. Orr, 424 Colorado Drive, Erie, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. Third St., Harrisburg, Pa.

Rhode Island
The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina
The South Carolina Board of Chiropody Examiners. **Board Secretary:** Dr. Charles W. Clark, 535 Harden St., Five Points, Columbia, South Carolina.

South Dakota
The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Dr. Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. D.

Tennessee
The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, D.S.C. 3355 Poplar Ave., Memphis, Tenn.

Texas
The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Texas.

Utah
The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont
Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia
Virginia Board of Medical Examiners. **Board Secretary:** Kenneth D. Graves, M.D., 631 First St., S.W., Roanoke, Va.

Washington
The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July, in Seattle. **Board Secretary:** Thomas A. Carter, Department of Licenses, Olympia, Wash.

West Virginia
Medical Licensing Board of West Virginia will meet for examination. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin
The Wisconsin State Board of Examiners. **Board Secretary:** O. J. Trimborn, D.S.C., 208 E. Wisconsin Ave., Milwaukee 2, Wis.

Wyoming
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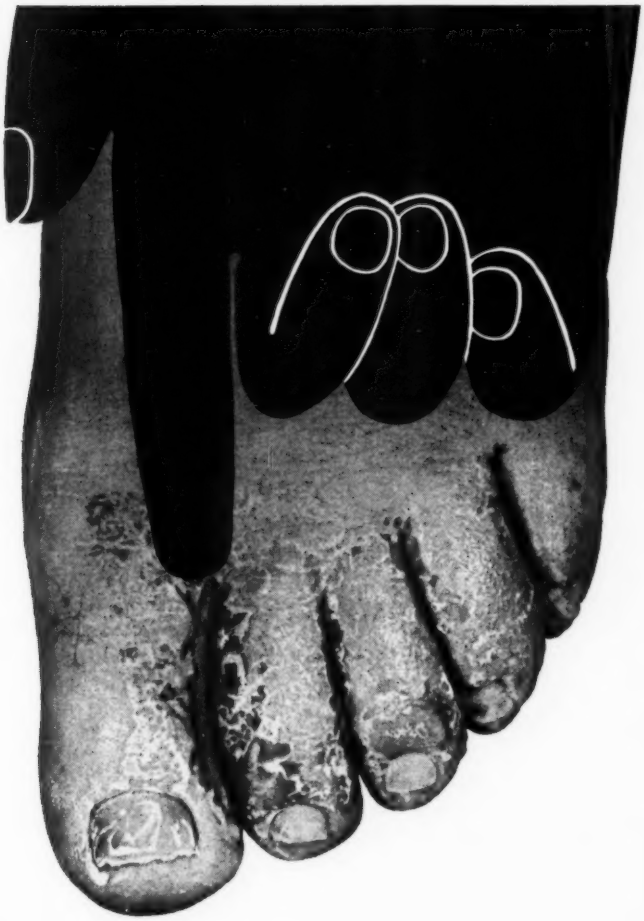

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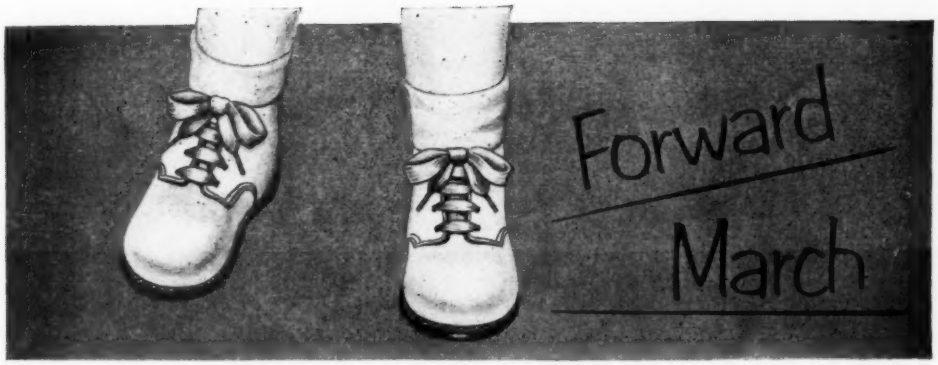

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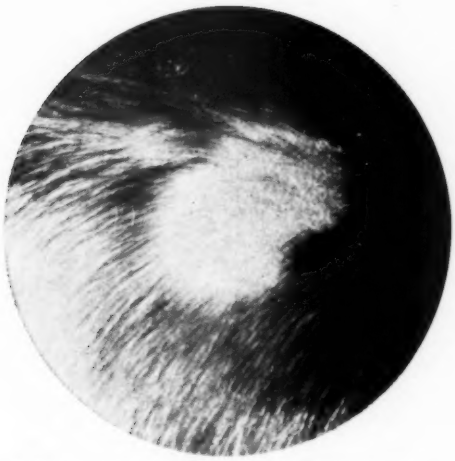

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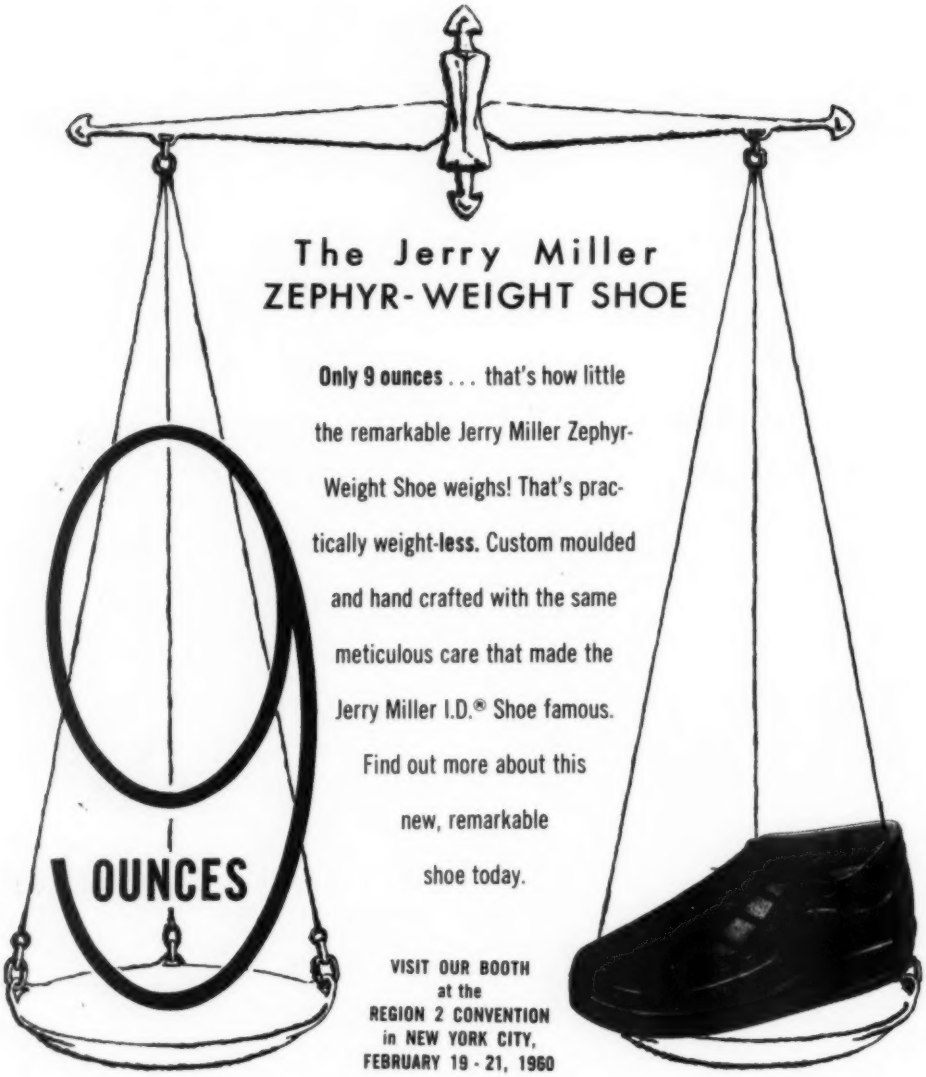

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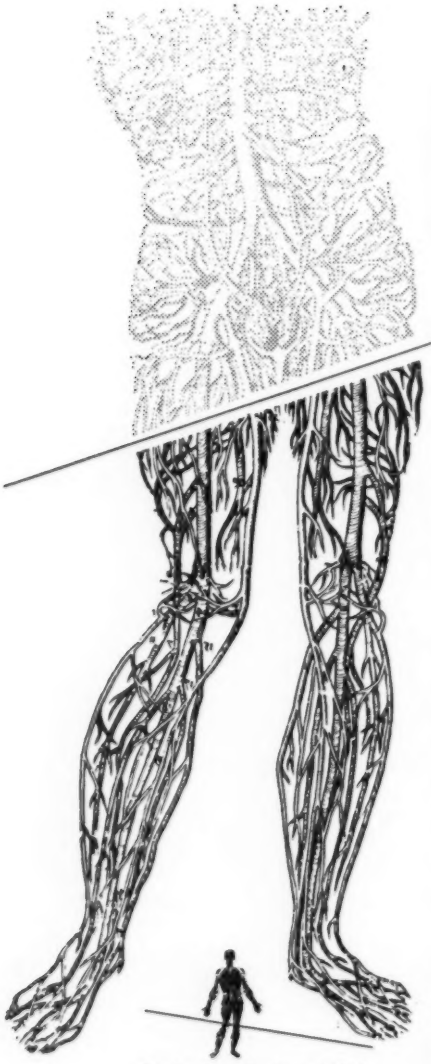

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ELIMINATION OF ONYCHAUXIS BY SURGERY*

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ONYCHAUXIS, according to Taber's Medical Dictionary, is the "hypertrophy of the nails." This entity has been a very perplexing problem for a great number of years, as it has been notoriously resistant to treatment. Many preparations have been thoroughly tested and the literature is full of theory and practice involving the treatment of this condition. Most of them have proved inadequate therapeutically and failure is the rule instead of the exception.

Etiology

The etiology of onychauxis is varied with a great many causative factors. The greatest single factor is trauma. Here a hemorrhage beneath the nail causes a subungual hematoma and also damage to the nail bed, and the result is a thickened or clubbed nail.

Systemic diseases often cause this condition, among which are peripheral stasis, peripheral neuritis, syphilis, leprosy, and hemiplegia.

Dermatological disorders, especially fungous conditions, cause a great proportion of these conditions. Other dermatoses involved are psoriasis, lichen pilaris, eczema, exfoliative dermatitis and varied types of contact dermatitis.

Other causes, although more infrequently seen, are certain endocrine dysfunctions, e.g. onychogryposis (a form of onychauxis) in acromegaly.

Heredity and bacteriological infections also provide additional methods of acquiring this most common disorder.

Treatment

Several surgical procedures have been advanced in the past, all with some degree of success, but since recurrences were frequent surgical intervention was rare. Only one method, the Symes' partial amputation, stood the test of time and proved successful. This too had its disadvantages, largely because, although a nail never regenerated, a short toe resulted. The desired cosmetic result was, therefore, a failure also, since the shortened toe and disfigured foot caused more attention than did the clubbed or disfigured nail. Therefore this method too was not acceptable, except on the lesser toes, where it is still considered good procedure.

In the Symes' Partial Amputation, two semi-eliptical incisions are made, one

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proximal and one distal to the nail plate and the entire area is completely removed, including the nail, nail bed, subcutaneous tissue, nail folds, and surrounding tissues. The distal phalanx is then separated and is partially amputated (approximately two-thirds is removed, according to the size of the flap needed). The plantar flap of skin tissue left is then sutured dorsally to complete closure.

The technique which is now about to be described was originated in order to:

1. Completely eradicate the club nail so that it would never re-occur.

2. Give a good cosmetic effect without any shortening of the toe or other disfigurement.

3. Be a simplified technique that most chiropodists could do without intensive surgical training in this procedure.

4. Give the patient the desired result without severe postoperative pain and little time loss from employment.

5. Give a satisfactory result without regard to etiology.

It must be noted here that over five hundred cases could have been reported; however, the only ones reported are those patients who have been followed up for over a year's period, and the results noted.

Surgical Procedure

In the present series of 359 cases, the following procedure was used without a single recurrence or residual disability. In Table I, "Improved" should be interpreted as a club nail which was successfully removed with no recurrence, however, some nail growth did regenerate. This growth was very superficial and peeled off in bathing, but could not be classified as excellent. This failure, if it might be classified as such, was due to incomplete removal of a small portion of the nail bed.

1. The first toe, after proper surgical preparation, is "block" anesthetized about the base using 1 or 2% Xylocaine®[1] with 1:100,000 epinephrine in a 5 cc. syringe with 25-26 gauge one-inch needle.

TABLE I

		Male	Female
Total Number of Cases	359	140	219
Exostosis present	269	92	177
Results	Excellent	Improved	Failure
Female	219	8	0
Male	132	6	0

2. Using the handle end of a Bard-Parker Scalpel, the nail is avulsed by forcing the handle under the nail and separating it from the nail bed, removing it completely by blunt dissection.

3. The foot is now given a complete surgical prep and a tourniquet is applied.

4. Two linear incisions 1.5 cm. in length are made, one on each of the medial and lateral aspects of the posterior eponychium following the nail fold lines, and extending proximally to just short of the interphalangeal joint. This area is separated by sharp dissection at the nail level depth and is retracted exposing the matrix area. A third curved incision is made at the distal end of the toe connecting the nail folds.

The nail bed is dissected sharply from the phalanx. After separation has begun, a thumb and finger forcep or an Allis clamp is used and the entire nail bed is completely removed along the dorsal surface of the proximal phalanx. This extends the length of the phalanx to its base where the matrix is attached to the bone, just distal to the tendon attachment. Removing completely the nail bed and matrix leaves only the exposed phalanx.

At this point, any exostosis involvement is removed with bone nippers or rongeurs.

5. The retracted eponychium flap is now replaced and held in position with 000 silk simple sutures, one on each of the medial and lateral incisions.

[1] Astra

Postoperative Care

Postoperative care in this procedure is of the utmost importance and must be carefully followed. The surgery just described leaves the first phalanx completely exposed. This area will heal completely in approximately four-to-six weeks by third intention. Patients are advised that they will have little or no discomfort after the first few days but the area must be kept covered or bandaged at all times for four-to-six weeks until an eschar appears and peels off, leaving a smooth healed surface.

Step by step postoperative care is as follows: The surgical dressings are not removed until the seventh or eighth day when the sutures are removed under aseptic conditions, unless an infection, swelling, or any other complication intervenes. If the dressing must be replaced earlier by a smaller dressing, only the outer portion is removed leaving that portion adjacent to wound and redressed from that point.

A second visit is scheduled in four to five days at which time hydrotherapy is given for 10-15 minutes and the area is redressed with a water soluble ointment. At the third visit, in another five days, the same treatment is repeated.

The patient and treatment continue as indicated for four or five visits until the drainage has stopped or lessened. Then 5% silver nitrate solution is applied and can be prescribed for the patient to continue at home.

Patients are reappointed at weekly intervals until a complete eschar crust is formed. This eschar forms in approximately four-to-six weeks. When peeled off, a clear smooth surface of epidermis appears where the nail was.

Fig. 1. 10 week postoperative appearance, following surgery for onychauxis as described in text.

Postoperative pain is controlled usually by any of the A.P.C. compounds. In some cases, it may be necessary to add a half grain of codeine.

The complications of this type of surgery are few, postoperative infection being the most frequent. This is easily controlled with antibiotic ointments or oral administration of antibiotics. This complication is not common and is easily eliminated.

Summary

In evaluating the results of this study, it has been my experience that in dealing with this almost impossible therapeutic problem and regardless of etiological factors, the surgical approach described offers a complete solution to the problem of onychauxis.

14608 Gratiot Ave.

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"Let no one follow what he thinks most profitable to himself but rather what is best for another."

St. Benedict of Nursia
480-543 A. D.

ROLE OF CHRONIC TOXIC PROLIFERATIVE PERIOSTITIS IN ONYCHOINCURVATUS AND SURGICAL MANAGEMENT*

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SUBUNGUAL osteoma may occur as a single entity or may be commonly associated with incurvated nail plates. The term subungual osteoma merely defines the location of the lesion, but fails to pinpoint the basic pathological condition.

In most instances of nail disorders there is an associated deformity of the underlying osseous tissue. These osseous deformities are generally present on the distal aspect of the distal phalanx or at the medial and lateral aspect of the base of the distal phalanx. Many of the apparently simple incurvated nail plates that are commonly seen in the doctor's office are but symptoms of a generalized problem which may or may not be in a state of active process.

When an incurvated nail occurs, be it suppurative or nonsuppurative, and especially when the nail is chronically incurvated, there is an associated periostitis of the distal phalanx. If this periostitis is prolonged it would be far more correct to term the condition chronic toxic proliferative periostitis. The incurvated nail plates then become the symptom of the true pathology just as pain may be indicative of a weak muscle, ligament, or generalized disability.

Film studies will always reveal osseous deformities present. Some of the more common synonyms describing proliferative periostitis of the phalanges are clubbed fingers, Hippocratic fingers, achropachy, chronic hypertrophic osteo-arthropathy, toxiogenic osteo-periostitis, secondary ossifying periostitis, Marie Bambergers disease, and hyperplastic periostitis.[1]

The purpose of this paper is to present a feasible surgical approach to the problem as it presents itself. The method has been repeated many times in the past four years without untoward incident or known failure. Osseous proliferation of the distal phalanx of any digit, wherever located on the distal phalanx, and when associated with deformities (incurvation) of the medial or lateral portions of the nail tissue, may easily be approached in the following fashion.

The involved digit is completely anesthetized by block infiltration. Tourniquets may or may not be necessarily employed to the base of the phalanges. Tourniquets provide a bloodless field; however, it is possible to perform surgical procedures on phalanges without the use of tourniquets. When surgery can be performed on a phalanx without constriction it is best to do so, because the absence of normal circulatory rates plays a role in postoperative healing and subsequent surgical success. The preceding statement is more applicable in lengthy procedures.

The description will follow a case having an osseous deformity on both sides of the base of distal phalanx, and the dorsum of the distal portion of the distal phalanx.

On the medial side of the nail plate an incision is started at the medial 1/8 distal end and carried posteriorly, longitudinally through the nail plate and matrix. The instrument of choice is a straight nail splitter, because one can more easily determine the direction of the cutting edge of the instrument and because of the narrowness of the instrument only the nail plate is incised. Heavier instruments, such as nail forceps, tend to produce excessive surgical trauma. On reaching the eponychium the nail splitter is continued posteriorly through the nail matrix which in most cases extends to the proximal aspect of the base of the distal phalanx.

*Paper awarded Honorable Mention in the William J. Stickel Awards for Research in Podiatry-Chiropody 1959. Presented at the Annual Meeting of the A.P.A. at the Waldorf-Astoria, New York, N. Y., August, 1959.

The incision is then continued with a #10 blade, following the nail plate incision, and extended through the nail matrix to a point just anterior to the base of the distal phalanx. The posterior termination of this incision should not be located over the interphalangeal articulation because joint motion can interfere with postoperative healing.

A second incision commencing at the posterior termination of the original incision is made at right angles or 1.0 to 1.5 cm. so as to form an "L" shaped flap. This "L" shaped flap must be of a size to completely expose any portion of the nail matrix which may have been displaced medially and inferiorly by extraneous macrotrauma from heavy objects, or static microtrauma resulting from insulting footgear such as shoes or stockings. This exposure also facilitates adequate exposure of the medial aspect of base of the phalanx.

At the vertex of the right angle thus formed a third incision is made, directed anteriorly and slightly elliptically so as to include the nail lip. The nail lip is included because in many cases of incurvated nail plates there is an hypertrophy of the nail lip which, if not excised, will require further treatment. At the origin of the third incision care must be exercised so as not to contact the matrix and interfere with its integrity. The third incision should terminate at the distal end of the phalanx at the most inferior part of the original skin incision which is deepened 0.3 cm. inferior to the nail bed at the distal end of the phalanx. At a point opposite the anterior end of the lunula the third incision should be deepened with a #15 blade so that the flap makes a "V" with the medial side of the phalanx. The skin flap thus formed is dissected free and is retracted medially. The incision is then deepened through the nail matrix by following the lines of the original right angle cutaneous incision.

The section of nail plate, lip, and bed, bounded by incisions "one" and "three" is then grasped with an Allis forceps at its anterior end, dissected free, retracting posteriorly, and is completely excised along with the corresponding area of nail matrix.

This technic, as in this case, is often performed on both sides of the digit.

Following the excision described the dorsal aspect of the base of the distal phalanx is exposed. The offending portion of osseous tissue can then be completely excised.

When a subungual osteoma is present, the nail bed is dissected free from the dorsal and distal aspect of the distal phalanx. Care must be exercised so as not to injure or destroy the integrity of the nail bed. The nail bed is then retracted dorsally so as to expose as much of the distal phalanx as is required. The osteoma is then excised completely. When there is extensive osseous hypertrophy, up to two-thirds of the distal phalanx may be excised.

The margins of each cutaneous incision are then coaptated and sutured with 000 nylon single interrupted sutures.

If there is a coexistent onychomycosis the nail plate is dissected free by sharp dissection following the closure of the cutaneous incisions.

Summary

While there are many avenues of approach for subungual osteoma the purpose of this paper is to present a different technic which treats firstly, the symptom, incurvated nail plates; secondly, the cause, proliferative periostitis; thirdly, presents a technic which produces excellent functional and cosmetic results with a mimium of postoperative complications.

114 South Woodward Ave.

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MOBILIZING ADHESIONS WITH NEGATIVE PRESSURE

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THIS procedure is a new approach to an old problem which I believe has much merit in the treatment of the papilloma.

The papilloma (plantar heloma) is a dehydrated hard mass varying in size from a pin-head to a large pea and is found in the papillary layer of the skin, on the plantar surface of the foot. And, I believe, its origin is trauma, presumably from a sharp object or pinched tissue or the nails in low-heeled shoes or the screw in the high-heeled shoes. They usually are located near or under one or more of any of the metatarsal heads, and they are also found on the plantar surface of the os calsis. After many years of walking on these stone-like chronic conditions, despite occasional palliative treatment, they continue to reoccur. I believe that the reason they do not resolve is that there are adhesions deep to the growth as suggested by Austin.[1] If the adhesions are mobilized, it should solve the problem.

There have been many types of treatments and procedures for the elimination of this condition such as escharotics, injection therapy, appliances, electro-dessication, surgery, x-ray therapy, etc. Nevertheless, over many years my experiences with the foregoing were, percentage-wise, not too successful.

The approach described here is to attack the growth by severing and mobilizing the fibers of the adhesions. This is accomplished by the use of a suction (negative pressure) machine with a minimum pressure of 20 pounds of mercury for a specific treatment time. The patient will experience the sensations of the tearing or separations. However, it is not painful if the "pull" of the suction-valve is controlled so that the negative pressure is increased gradually to the patient's tolerance.

First all the callous tissue and then as much of the papilloma as is possible is reduced with a Solberg Burr*. This burr requires some experience in its use and should be applied deftly and cautiously until such experience has been had. Avoid hemorrhage at this stage of the treatment. However, if it does occur, use a styptic (Monsels Powder) and wait a few minutes before proceeding.

A 1/6th h.p. Aspirator** suction machine is used. One yard of rubber tubing extends from the machine to a cup or to a bifurcated glass tube. Glass suctions cups can be made by a glass-blower in diameters of ½" (oval for digits) and ¾", 1", and 1½" round, to fit the various types and sizes of conditions to be treated. For a multiple treatment, it is necessary to have the bifurcated tubes to which is attached the 12" tubing then to the cups. Tube-clamps are used for the multiple procedure to clamp each tube independently. The valve is opened and the gauge is brought to 20 lbs. pressure, the cup is applied and positioned, and then the clamp is released. Increase pressure of suction depending upon the tolerance of the patient. Application for 10 minutes appears to be satisfactory.

Treatments are administered one week apart. At each succeeding visit, again reduce the callous tissue with scapel or a 7/8th coarse garnet disc on a mandril. Sponge with alcohol to clearly outline the growth. Apply suction for 10 minutes, then sponge with alcohol again.

If patient's tolerance does not permit reduction of the excrescence to a sufficient depth, spray ethyl chloride over the area, controlling the spray by turning it on and

*Solberg Burr, Beloit, Wis.
**Gomco Co.

off to maintain the necessary degree of anesthesia while using the scalpel, Burr or disc. Then continue to carefully reduce the growth as much as possible. Should hemorrhage occur use the styptic and again sponge with alcohol and repeat if necessary. Massage Panthoderm® into growth. Apply cut-out or any preferred type of pad. Should the pad be removed by the patient, have patient massage Panthoderm into the tissue daily. With each treatment, the condition will diminish eventually appearing only as an excrescence. Use the small Solberg Burr when necessary until the condition disappears entirely.

In many cases, the results were quick and dramatic. In the more chronic ones, the results were satisfactory but took longer. Eventually, the condition was eliminated or definitely improved, more so than with other procedure in my experience.

I have had excellent results with this procedure on heloma durum with adhesions, veruccae, cicatrix from electro-dessication, surgery, and x-ray burns resulting from the treatment of veruccae. Also equally good results were obtained on two chronic cases of very painful scar tissue with adhesions from trauma and surgery, at the attachment of the tendo-achille.

In one year my experience with this modality is: of 107 cases, 16 patients did not continue after the 1st or 2nd visit for a variety of reasons; 3 fair results; 7 had multiple growth of which some are healed, the remaining ones are under treatment; 9 are presently under treatment; and 72 are completely healed and discharged with no recurrence visible at periodic checks.

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Comment

Severing the adhesions surgically as suggested by Austin will likely result in more adhesions. Repeated administration of negative pressure at regular intervals should mobilize the adhesion so that the surface tissue will not be bound down, but will be freely movable.

15921 W. Seven Mile Rd.

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To buy hyacinths for the soul—to nourish your mind and heart with good reading; to become informed, alert, interesting in what you say to others—is just as important as progress in your business or profession.

If thou hast two pennies, spend one for bread. With the other buy hyacinths for thy soul.

Persian Poet

STAINLESS STEEL WIRE SUTURING*

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STAINLESS Steel Wire in Foot Surgery (skin) has been used exclusively for the past two years by the author. I believe it can be used in skin to a much better advantage than other kinds and types of suture materials. It does, however, require more skill and practice to be able to handle it with speed and proficiency.

Fig. 1. Start of wire suture

Some of the advantages of wire are:

1. Minimal skin irritation
2. Ease of removal
3. Broad methods of sterilization
4. The variance of time in which the suture may be left in place
5. The low cost of material.

Suturing Materials: ½" circle, cutting edge needle #1834-9, Anchor Brand Needle or its equivalent. #35 Stainless Steel Wire .005" Diameter. (#34 or #36 can also be used.)

Types of Sutures: (1) Sub-cuticular, (2) Interrupted, (3) Purse string, (4) Nail Cross-Over (Nail lip closure).

The sub-cuticular suture is the one most commonly used. It is not difficult to do, but it takes patience and practice before one becomes proficient. The thickness of the skin where the suture is to be placed must be taken into consideration. This thickness varies with each individual and with each area of the foot.

With a 15" length of wire threaded through the needle about an inch, wind the short end tightly around the long strand several times. The wire is drawn through the skin outside of the incision, as in Fig. 1, at the end farther from the operator. The second step is to run the suture through the skin edge if skin is thick enough. If unable to thread wire through because skin is thin, evert the edge and thread through from the bottom being careful to stay close to the edge for better closure when suturing is completed. (Fig. 2 shows incision half closed.) After the last

Fig. 2. Suture half completed

suture is placed, exit is made outside the end of the incision near the operator (Fig. 3).

Only the first half of the wire has been used for suturing up to this point. When

*Paper read at The American College of Foot Surgeons Meeting, Las Vegas, Nevada, Feb. 1959.

Fig. 3. Completed suture

all suturing is completed the free half of the wire is retracted through so that it occupies the place of the first half—this will make for easier removal later because it eliminates bends and kinks which may have been introduced in the suturing. Avoid any kinks which may cause the wire to break or which may tear the tissue.

Interrupted sutures may be placed where any gaping may occur when suturing subcuticularly along the incision. These are placed singularly and spaced as desired. Interrupted sutures are used in small straight incisions, and also in curved incisions. In incisions 2" long or longer a loop can be placed when half way; come through the skin and make entrance with the needle on the opposite side and begin suturing as before. When removing, the "loop" is cut at the entrance into the skin and with hemostats on the free ends, the suture is gently pulled out.

Do not tie wire or use mattress sutures but merely twist clockwise while holding suture taut with little or no tension on the skin edges. This will eliminate cutting by the wire when edema occurs in the healing process. When removing, untwist (counterclockwise). If one forms the habit of using a clockwise twist, it will expedite removal.

Purse string sutures of wires are used primarily in closing small circular incisions such as are made when removing a deep plantar keratoma. After the lesion is dissected out this type of suture is applied to effect a smaller opening which will assist coagulation and stop hemorrhage. I usually remove this type of suture on the day following the initial surgery.

A cross-over suture to the opposite side can be used to hold nail lips in place following nail surgery. When both sides of the nail are to be sutured the needle is placed in the skin from the outside on the initial lip and from the inside on the opposite lip, making sure that the wire is placed beneath

Fig. 4. Incision, 30 days postoperative sutured with wire.

the distal free edge of the remaining nail. Then the ends of wire are crossed over the nail and twisted twice with little or no tension on the skin edges. A second similar suture can then be placed distally. In this manner the nail lips are forced downward, toward the nail bed away from the nail plate.

Fig. 4 shows an incision sutured with wire, 30 days postoperative.

405 Professional Building

OFFICE DETERMINATION OF PLASMA PROTEIN HEMOGLOBIN AND HEMATOCRIT

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Introduction

THE determination of plasma proteins, hemoglobin and hematocrit can be of great value to the podiatrist in diagnosis and pre-operative evaluations. This paper is a short discussion of the basic information so proper interpretation can be made. The procedures, it will be seen, are simple, fast, clean and inexpensive.

Hemoglobin

The origin of hemoglobin is obscure but probably begins in the liver and is completed in the bone marrow. One gram of hemoglobin is capable of combining with 1.34 c.c. of oxygen. The average normal is 15.6 gm. in the adult male and 13.7 gm. in the female. Doan suggests that each individual establishes an equilibrium for hemoglobin and red cells at the optimum for his oxidation requirement but with a reserve of red cells.

Hematocrit

Variations in the volume of red cells are equally as important as their number and hemoglobin content. The hematocrit measures the relative volumes of the plasma and red blood cells. It may be used to determine the volume index (V. I.) and mean corpuscular volume (M.C.V.) of red cells providing an accurate red cell count is made. The normal adult male has a hematocrit of 45 to 46 c.c. per 100 c.c. of blood, with 42 c.c. being normal in women. The average is 43.2 c.c. per 100 c.c. of blood.

The volume per cent of packed red cells indicates only the relative volume of the mass of red cells in circulation as compared with normal. When volume index is normal, the indication is normocytic. The volume is a direct indication of oligocythemia or polycythemia. If the volume is large in relation to cell count it indicates macrocytosis, if small it indicates microcytosis.

Proteins

The total proteins of the blood are made up of three main proteins which are albumin, globulin and fibrinogen. For practical purposes only the albumin and globulin are usually determined clinically. Both of these have several factors but again for practical purposes are determined as one.

Direct evidence indicates the origin of fibrinogen and albumin is in the liver and that globulin is formed in the reticuloendothelial system.

The functions of the proteins are not thoroughly understood though they have been extensively investigated. Fibrinogen is well known to have a function in coagulation of the blood. Albumin is concerned in fluid balance, tissue equilibrium and repair. Globulin is related to the formation of immune bodies. The normal plasma protein in adults varies between 6.0 and 7.5 grams per 100 c.c. . . . Albumin fractions 4.5 to 5.5 grams and globulin 1.5 to 2.5 grams per 100 c.c. This relationship is called the albumin-globulin ratio (A-G) and is normally 1.5 to 2.5 to 1.

The majority of the abnormal plasma protein concentrations fall into three categories:

1. Those with low total protein (hypoproteinemia) in which albumin is reduced and globulin is normal or only slightly reduced.
2. Alternations in which the total protein lies within normal limits but there is both decreased albumin and increased globulin.
3. Those with elevated total protein (hyperproteinemia) showing increased globulin and normal albumin.

Hypoproteinemic states occur from deficient intake, excessive loss of protein, liver damage with an inability to fabricate protein. The chief manifestation clinically is edema. The normal fluid balance between the vascular system and the tissue is the most important function of albumin. The large size albumin molecule is unable to pass the semi-permeable membrane of the capillary wall and therefore exerts a positive osmotic pressure which, unless exceeded by the blood pressure, results in a passage of fluid from the tissues into the blood vessels. The balance between blood pressure and osmotic pressure is probably the single greatest factor in the preservation of normal fluid distribution. In the arterial end of the capillary loop, the blood pressure exceeds osmotic pressure and fluid passes from the vessel into the tissue at the distal end of the capillary, venous blood pressure is less than osmotic pressure and tissue fluid then returns to the vessel, thus preserving normal balance. Hence a depletion of plasma albumin causes a lower osmotic pressure and may reach a point where it equals or is less than venous blood pressure which results in an accumulation of fluid in the tissue. A low protein value insufficient to produce edema delays the healing of wounds and the attendant decrease in gamma globulin predisposes to post-operative infection.

Excessive loss of proteins is seen chiefly in kidney disease and characterized by prolonged albuminuria. Albumin deficiency due to hepatic dysfunction is seen to a slight degree in acute, but more strikingly, in chronic liver diseases. Albumin decrease and globulin increase may be seen in carcinomatosis of the liver, acute glomerulonephritis and with the simultaneous occurrence of two diseases, one causing lowered albumin and the other elevated globulin, as for example, tuberculosis and malnutrition. Hyperproteinemia and hyperglobulinemia are practically synonymous. Hyperglobulinemia may be considered to be present above 3.0 gram or in total protein 8.0 gram and above. These are observed in decreases of the bone marrow, such as leukemia, multiple myeloma and metastatic tumors, in chronic infections, both suppurative and nonsuppurative.

Copper Sulfate Method for Determination of Specific Gravities of Whole Blood and Plasma

The method described by Phillips, Van Syke, Dale, Emerson, Hamilton, Archibald, Stanley and Plaszen makes it possible to determine within a plus or minus two per cent the hemoglobin, hematocrit and plasma proteins. The determinations are easily done with a minimum of time and therefore are suitable office procedures within the realm of the average podiatrist. The procedure for setting up the standard solutions are not difficult but are time consuming and require the use of volumetric flasks, burrettes, etc., which are only rarely found in a podiatrist's office. All things considered it is the opinion of the author that our purposes would best be served by the purchase of the standards from a supply house.*

Technique

One drop of whole blood or plasma is dropped from a dropper or syringe into a solution of copper sulfate of known specific gravity. Each drop on entering the solution becomes encased in a sack of copper proteinate and remains as a discrete drop without change of gravity for fifteen or twenty seconds, during which its rise or fall reveals its relative gravity to that of the solution. The speed with which the drop rises or falls gives an indication of how far off you are and by repeating the procedure with subsequent standards, you establish the correct gravity, which is when the drop

* Harleco, 60th & Woodland Ave., Phila. 43, Pa., has for sale the stock solution from which the series can be made. It likewise has various size sets which range from sixty in the series which has increments of 0.001 to the sixteen solution set which has increments of 0.004. The latter set is not expensive and is sufficient for the type work we will be doing, and it covers the entire range of whole blood and plasma which is 1.016 to 1.075.

will hover for a minute or so. The copper sulfate solution automatically clears itself after each test, because within a minute or two after the test the material settles to the bottom. One bottle of standard then becomes reusable for many tests.

Procedure

1. Tourniquet should not be applied for more than one minute.
2. Whole blood can be used but most of the procedures call for blood and plasma, so draw 10.0 c.c. of blood and transfer to a tube previously prepared with one c.c. of Heller and Paul oxalate mixture. This tube is prepared by making a stock solution containing 1.2 gm. of ammonium oxalate and 0.8 gm. of potassium oxalate per 100 c.c. of water. One c.c. of the mixture is placed in a suitable tube and allowed to dry. The blood is inverted in this tube at least ten times to insure mixture. No other anticoagulant should be used as it creates error. If the testing on the whole blood part is not done at once make sure the sample is mixed. The tube can then be left standing in a verticle position or centrifuged to obtain the plasma off the top (yellowish fluid).
3. In order to increase the life of the standards, the testing should be done with a fine pointed dropper. Greasing the tip with vaseline or caprilic alcohol reduces the size of the drop further, though it is not necessary.
4. A drop of whole blood is discharged from a height of about one cm. above the solution. This penetrates two to three cm. below the surface and within five seconds the momentum is lost and the drop either begins to rise or fall or becomes stationary. The behavior during the ten seconds after momentum indicates whether it is lighter or heavier or the same. In using the 0.004 range set it will at times have to be judged between the sets one way or the other by the action of the sets on both sides. An error of 0.001 in plasma gravity affects plasma proteins by 0.4 grams per 100 c.c. Additive errors of 0.001 in gravities of both plasma and whole blood affect hemaglobin results by seven per cent.

Calculation

Line charts for the calculation of plasma protein concentration, hemoglobin and hematocrit are also available from "Harleco." Plasma protein concentrations are read directly from the plasma gravities scale on the left of each figure. Hemoglobin and hematocrit values are estimated by laying a straight edge across the charts. Oxalate anticoagulant calls for a correction to be made and this is indicated at the bottom of the chart.

Notes

A standard solution receives about one-fortieth its volume before changed. Therefore the four ounce bottles of Harleco should take about 120 tests. Separate replacements may be purchased.

Standards should be used at temperatures of the samples. Storage should be such that hot and cold temperatures are avoided.

Occasionally a drop will fail to break clean from the surface and must be dislodged before the next test. Do so by tapping bottle with wooden applicator.

Summary

The use of copper sulfate standard solutions is a quick, clean, accurate way of establishing plasma protein, hemoglobin and hematocrit within our office. These determinations have value as a pre-operative procedure as well as in diagnosis. The author as in previous articles feels procedures which are at hand will be used more frequently than those which must be sent outside the office.

513 Breier Bldg.

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CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

SURGICAL PROCEDURE ON A DIABETIC

Case History

C. A. TRETHEWEY, D.S.C.
Owosso, Mich.

History

WHITE male, age 55, height 6'1", small frame, 170 weight, occupation truck driver. Ten to fifteen years ago, patient had a recurrent non-healing papule on the upper left forehead and inner upper 1/3 of the nose, with repeated history of drainage and escharing only to break down again. This had been diagnosed as squamous cell carcinoma and was surgically removed. Patient gives history of an arrested case of diabetes, having been put on insulin daily at time of detection, when the lesions of the forehead and face were removed. Patient is no longer on insulin.

Present Complaint

A nucleated heavy callus covering 2-4th metatarsal head area, proximal to and including the ball of the foot with sinus. Also present and because of past medical history considered significant, was a benign neoplastic lesion on the lateral side of the great toe.

Cause of Treatment

Debridement of calloused area. A sinus was exposed containing a serous non-sanguineous fluid. Drainage gave patient immediate relief. Sinus area was 1" in diameter. Area dressed with Tubegauze®[1] applying Aureomycin®[2] directly to the area. Boric Acid soaks, 20 min. b.i.d. were prescribed. Albamycin®[3] 250 mg 1 q. 6 hrs. with a full glass water-milk was also prescribed. Patient was directed to check every morning and evening for urine sugar.

7th day: Area clearing, patient asymptomatic. Redressed as above.

14th day: Area clearing, regeneration of tissue good. Urine has been sugar-free. Sinus draining very slightly. Accommodative, 1/8 felt and 2x2 ichthyol applied.

20th day: Checked area, progress excellent. Redressed accommodatively as above.

26th day: Area healed satisfactorily. Patient was again advised of the advisability of having the lesion at side of hallux surgically removed because of the history of squamous cell carcinoma of nose and forehead.

30th day: Patient, having had a complete physical examination by his family physician, returned for excision of lesion. Physician's report advised that urinalysis and complete blood count yielded no significant findings.

Patient was given 3/4 gr. Sodium Seconal®[4] 30 minutes before surgery. After surgical preparation, anesthesia was obtained by infiltrating 1-½ cc. Nesacaine Hydrochloride®[5]. The lesion was removed in toto through longitudinal semi-eliptic incisions. The incision was closed with an interrupted mattress suture of 000 silk. Codeine Phosphate No. 6 q. 3 h. was prescribed for postoperative pain if necessary.

Postoperative Course

Patient had no postoperative pain the following morning and was feeling fine. On the second postoperative day, the outer dressing was replaced. On the seventh postoperative day, site was completely re-

®[1] Scholl Mfg. Co.
®[2] Lederle ®[3] Upjohn
®[4] Lilly ®[5] Maltbie

dressed with Tn. Merthiolate®[6], Aureomycin and tubular gauze. On the fourteenth day sutures were removed and redressed as before. Line of incision was not completely closed. On the twentieth day no dressing was reapplied as healing was complete and patient was dismissed.

Pathologists Report

Specimen consists of Benign Neoplastic Tumor, lateral side of 1st phalangeal. Gross: The specimen consists of a raised, white, oval mass which measures 8x5x5 mm. This mass is covered by epithelium. The skin surrounding the base is normal in appearance. Tan, firm, connective tissue is found centrally. Microscopic: The sections show a papilloma-like structure lined by stratified squamous cell epithelium. Marked hyperkeratosis is seen. Diagnosis: Cornifying squamous cell papilloma. No malignancy.

C.E.B., M.D.

Comments

This case report was interesting for the following reasons:

A. The significance of a good preliminary past medical history is obvious.

B. It evidences the control necessary when treating a patient of arrested and controlled diabetes, and the unnecessary apprehension that some have in treating and performing a surgical procedure on a patient with controlled diabetes.

C. The technique of treatment remains the same, both chiropodically and surgically, in diabetic and nondiabetic; only a closer watch of the patient is required. Aseptic technique in all phases is especially important.

Matthews Building

®[6] Lilly

SURGICAL REMOVAL OF METAPLASTIC TISSUE OF GREAT TOE

PAUL D. HOULE, D.S.C.
Ft. Lauderdale, Fla.

PATIENT, a 49-year-old male, presented himself at the office because of pain beneath the right great toe upon walking. Examination revealed a large protuberance plantar to the interphalangeal joint of the right great toe. On palpation, the mass was firm to the touch and movable to some extent. The epithelium of this area was keratinized. An X-ray was taken and the area involved was interpreted as being an irregular mass of calcified tissue of the same density as bone. This mass was not connected by a bony union to any portion of the proximal or distal phalanx but remained isolated in the underlying soft tissue. The onset of this condition was approximately one year. Surgical removal was recommended.

Laboratory Findings: Hemoglobin 14.8 Gm., RBC's—4,200,000 p/c/mm, WBC's —10,300 p/c/mm; Differential Polys—66%, Eos — 3%, Monos — 2%, Lymphs — 29%. Urine negative for sugar and albumin. Pulse 86, blood pressure 115/75, bleeding time one minute, coagulation time 2 minutes. No previous history of any sensitivity to xylocaine injections.

Procedure: After sterile preparation, 3 cc. of Xylocaine®[1] 2% was infiltrated into the area. A double Martin bandage was applied to obtain a bloodless field. An inverted reversed L-shaped incision 4 cm. long was made with the apex on the medio-plantar surface of right great toe. The tissue was grasped at the apex of the incision with an Allis forceps and resected, making a flap superficial to the mass. This flap was retracted and held to one side. The mass was palpated and examined as to its extent and size. The mass was grasped with Allis For-

®[1] Astra

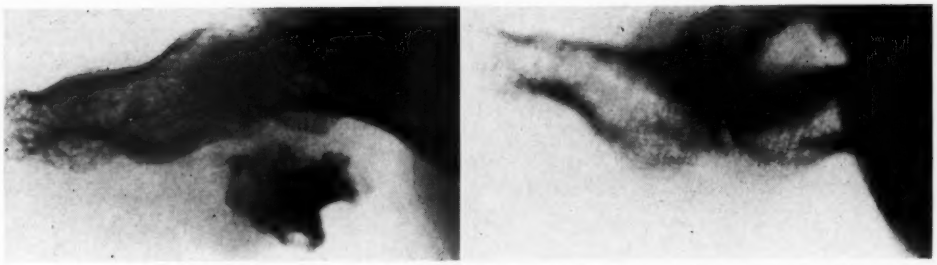

Fig. 1 Radiograph before (left) and after (right) surgery for a metaplastic calcification.

ceps and freed by blunt and sharp dissection.

It was placed in 10% Formalin solution for examination by a pathologist. The wound area was checked for further evidence of the mass. Loose fat and connective tissue was excised to insure that the mass was totally excised. The deep fascia was closed with two surgical gut sutures 000. The flap was replaced and held by five silk interrupted sutures. Postoperative medication for pain and antibiotics were prescribed. The usual postoperative redressings and treatment were carried out. The sutures were removed in 15 days. The area healed without complication and patient dismissed one month after surgery. There was no evidence of a mass in the area involved, confirmed by x-rays.

Pathologist Report

Gross Examination: Specimen consists of a nodular 15 x 10 x 8 mm partially calcified mass. After decalcification sections will be made.

Micro Examination: There are bony trabeculi in which the osteocytes are intact within their lacunae. These merge with zones of hyaline cartilage and dense connective tissue. The intervening zones are composed of mature adipose tissue.

Diagnosis: No evidence of malignant alteration. Metaplastic calcification of tissue from beneath proximal phalanx-foot.

Metaplastic Tissue Reactions

Metaplasia is change in the type of adult cells in a tissue to a form which is not normal for that tissue.[1] In the condition described, the area of metaplastic tissue reaction was plantar to the interphalangeal joint of the right hallux. The normal adult cells in this area are mostly connective tissue cells of the tendons and ligaments. Thus in this instance the metaplastic tissue reaction is that of connective tissue changing into bone tissue.

Examples of connective tissue metaplasia are common. Fibrous tissue, myxomatous tissue, cartilage and bone are all closely related and one may become changed into the other. The commonest change is that of cartilage into bone. In old age ossification of the laryngeal and tracheal cartilages is common. Bone may be formed also in the walls of degenerated arteries, the seat of arteriosclerosis.[2] These conditions we are all familiar with but we have to ask ourselves why did such a change take place in the present area. It seems that in some instances connective tissue metaplasia takes place in chronic inflammatory irritations due to the influence of simple mechanical forces acting from the outside, such as pressure, particularly when combined with friction.[3] Thus we can assume that the metaplastic calcification of tissue found in this area was due to excessive irritation and pressure applied to connective tissues during walking.

2961 W. Broward Blvd.

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GLOMUS TUMOR

DONALD L. PLOTNICK, D.S.C.
Columbus, Ohio

THE glomus tumor is a rare, benign, painful small neoplasm usually involving the skin and subcutaneous tissues. It is found mostly on the extremities. The neoplasm arises from the normally occuring glomus body which is an end organ structure composed of an arteriovenous anastomosis without an intervening capillary bed. There is a neuroreticular component associated with the glomus body that is thought to control the rate of blood flow through arteriovenous channels and thus help to regulate blood flow to the extremities and in consequence, to conserve or dissipate body heat.

When the glomus body or apparatus is fully dilated, there is a large dispersal of heat due to the greatly accelerated rate of blood flow. When the glomus is closed, the heat is conserved by shunting blood through the capillary network and away from the surface.

65 glomus bodies have been found in one large toe. They are concentrated in the nail bed of the distal phalanx. Therefore, it is not unexpected that glomus tumors will be in the terminal phalanges of the fingers and toes.

Those occurring in the nailbed may be very painful. Glomus tumors have been found in other parts of the dermis in the body area but it is very rare.

The glomus tumor is small, usually single, and there is little evidence to suggest any race or sex variation. Neither is there any significant age group for the tumor having been found in the very young as well as in the very old. The tumor rarely measures over one centimeter in size and is usually sharply demarcated and clearly visible; however, it may be so small as to be impalpable and only a very tender "trigger spot" may show the location of the tumor. The lesion appears as a circumscribed overgrowth with a characteristic bluish color (from grey to blue) seen under the nail. The tumor may vary in color depending upon the temperature. At room temperature or when cold the lesion appears greyish blue. In the presence of heat the lesion appears reddish pink.

The clinical symptoms resemble those of a neuroma and appear like an angioma. The clinical symptoms of a glomus tumor are, however, typical and unusually severe considering the size of the lesion. The condition starts with an attack of pain in a limited area and usually there is no visible evidence of anything pathologic. The pains increase and assume a stabbing or burning character. The slightest touch or temperature change may set off the pain and the patient may be forced to take marked protective measures in order to carry on normal activities. The tumor may pulsate slightly and the skin temperature may be elevated locally. When the tumor appears on the distal phalanx of the fingers or toes, it may resemble an overgrowth such as a verruca having a brownish or black color. Rarely, the tumor may affect the bone of a terminal phalanx, leading to destructive changes secondary to pressure; however, the tumor is benign and does not metastasize.

There are many treatments for the glomus tumor such as x-ray, fulgeration, hyfrecation, cryotherapy, but the treatment of choice is surgical removal of the tumor.

Local surgical excision leads to complete eradication of the glomus tumor. Heat, cold, and sympathectomy are without benefit. Under local infiltration the tumor itself can be dissected free with minimal loss of tissue. However, when the bone of the terminal phalanx is eroded, local amputation may be necessary.

When performing surgery upon the glomus tumor (if it is located under the nail), only the portion of nail over the lesion need be removed.

3354 E. Broad Street

EXOSTOSIS CARTILAGINEA OF THIRD METATARSAL

A Case Report

RICHARD C. PEARCE, D.S.C.
St. Louis, Missouri

A THIRTY-YEAR-OLD patient presented herself with a subjective complaint of pain in the right fore-foot for the past two years. The onset had been gradual and the pain was periodic but severe when it did occur. Shoe size changes were ineffective. It had been diagnosed as a "pinched nerve" and had been treated with ultra-sound and shoe padding, neither of which was productive of relief. No injection therapy had been given and the medical history was negative, without history of injury.

Microscropic examination revealed no color changes in the area, however there was a soft swelling dorsal to the third metatarsal interphalangeal space. Palpable pain was elicited on pressure from any direction. Various speculations were enterained but a tentative diagnosis of Mortons neuralgia was made and routine dorsal plantar x-rays were taken. No attempt was made to treat this condition at this time. The prospect of surgical intervention was dicussed and agreed to.

Upon examination of the film, a spotty oseous opacity was noted between the third and fourth metatarsal heads. This finding denied the tentative diagnosis and gave rise to various considerations, none of which could be verified until the lesion was delivered for section.

Complete blood count, and urinanalysis data were within normal limits. The operative procedure employed was under usual conditions of surgical asepsis. Anesthesia was obtained by infiltration of 3½ c.c. Xylocaine®[1] HCl 2%. Hemostasis was maintained by means of a Martin bandage.

A straight incision was made in the skin, between the shafts of the third and fourth metatarsal, from a point one and one-half inches posterior to the web and then forward into the web itself. This was deepened by blunt dissection to expose both the third and fourth metatarso-phalangeal articulations. At this point, it was obvious that the problem was within the capsule of the third metatarsal-phalangeal joint.

The capsule was incised, with the dorsal tendons retracted and the mass removed, it being attached by only a thin membrane. A pointed protrusion on the fibular side of the third head and posterior to the surgical neck was reduced with bone forceps and rasped smooth. The capsule was closed with one 00 chromic gut suture and the skin with a continuous lock silk suture.

Post operative instructions were to restrict weight bearing to bathroom privileges otherwise keep the part elevated and apply an ice pack.

On the third post-operative day, the top dressing was removed and fresh dressing applied. The patient stated that when the anesthetic wore off, she experienced slight pain which quickly responded to aspirin and the ice pack. Sutures were removed on the eighth day and the area dressed with a snug circular bandage around the fore foot. On the fourteenth day the dressing was reduced to merely cover the area and the patient discharged.

The removed specimen was represented by one irregularly shaped piece of tissue averaging about 6 mm. in diameter. The lesion was grey in color and on section, gross examination gave the impression that the entire specimen consisted of cartilage. A few diminutive light colored areas were present which could represent focal areas of calcification.

A microscopic examination of this lesion reveals that it is composed almost entirely of cartilage. A few small fragments of cancellous bone were noted around the periphery and a number of calcified areas were also encountered. This lesion was interpreted to represent an exostosis, sometimes referred to as an exostosis cartilaginea.

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TENDON DIVISION FOR DELIVERY OF DIGITAL PHALANGES

DONALD A. SCHUBERT, D.S.C., F.A.C.F.S.
Birmingham, Michigan

THE accepted technic of correction of flexion contracture (hammer toe) usually consists of a combination of any one of the following: condylectomy, joint resection, exostectomy and/or midphalangectomy. The extensor tendon is invariably involved in the correction of hammer toes. The purpose of this paper is to present a new technic employed on the extensor tendon which will permit the deliverance of as much of the proximal phalanx and middle phalanx as is necessary for correction of hammer toe deformity. This technic of tendon division may be employed on any toe; however, in this paper the procedure will be described for the fifth toe.

An incision is made commencing on the dorsal aspect of the fifth toe directly superior to the base of the proximal phalanx. The incision is then carried longitudinally forward to a point just anterior to the base of the distal phalanx. The margins of the incision are dissected free and retracted.

A longitudinal incision is then made into the extensor tendon corresponding to the length of the primary skin incision. The margins of the divided tendon are then carefully separated by sharp dissection. At the proximal interphalangeal articulation a number fifteen blade is slipped under the medial half of the tendon and by careful dissection the medial collateral ligaments of the proximal interphalangeal articulation are severed. The identical technic is then employed on the lateral side of the front.

The head of the proximal phalanx is then grasped with a mouse tooth forceps and dissected free by severing the capsular attachments of the flexor tendon from the plantar aspect of the head of the proximal phalanx. The head of the proximal phalanx is then delivered from the incision and is completely excised.

There are many instances where an osteophytic hypertrophy is present on the dorsal aspect of the base of the middle phalanx, and when this is so the base of the middle phalanx may also be delivered through the divided tendon and a complete exostectomy may be performed.

In many cases where osteophytosis is present on the base and head of the middle phalanx or if the middle phalanx is excessively small, it may be best to perform a complete midphalangectomy. There will be a lesser amount of postoperative pain and a shorter period of convalesence than when an exostectomy is performed. The middle phalanx demands attention in each case because with time the middle phalanx generally moves posteriorly to occupy the former position of the head of the proximal phalanx. This is why, in many cases, patients will have recurrence of the epidermal lesion. Neglecting to consider the middle phalanx is why many cases of apparently simple hammer toe corrections turn out to be surgical failures one to five years following the original surgical procedure.

The margins of the cutaneous incision are then coaptated and sutured with sutures of the surgeon's choice. Generally five to six 000 or 0000 nylon single interrupted sutures are sufficient to close the cutaneous incision.

Summary

Complete division of the extensor tendon requires a catgut suture. There is a tendency for deep sutures in the phalanges to be sloughed out. This may lead to incom-

plete union of the divided tendon with loss of function of the extensor tendon.

Dividing the extensor tendon eliminates excess suturing, allows for adequate exposure of the involved osseous tissue, and reduces the surgical trauma. This technic assists in promoting earlier postoperative recovery because the tendon covers the traumatized portion of the shaft of the proximal phalanx. Functional and cosmetic results are excellent.

114 S. Woodward Ave.

ECTRODACTYLIA

A Case Report

STEPHEN P. TOTH, B.S., M.A., D.S.C.
Shenandoah, Pa.

History

A WHITE, female patient, age 46, presented herself at the office with the complaints of muscular fatigue in both legs when standing for any period of time and on walking. She also stated that she had "Corns" on the tips of her toes.

Examination

Both feet revealed a congenital absence of portions of the toes of both feet. Also noted was a shortage of one and one-half inches of the left limb. There was an obvious scoliosis of the vertebral column.

Right Foot: Nucleated tyloma only on the third rudimentary toe. The medial, middle and lateral portions of the plantar aponeurosis were quite tense even on non-weight bearing.

Left Foot: Nucleated tylomata were seen at the distal plantar aspect of the great and third rudimentary toes respectively. Tylomata were also seen under the first and third metatarsal heads. Radiographic Studies: (See Fig. 1).

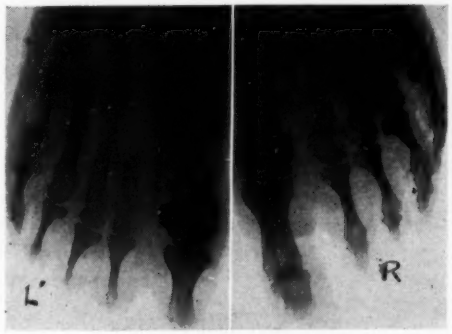

Fig. 1 Ectrodactylia

Right Foot: Dorso-Plantar View. Head of middle phalanges of the second and third toes not developed and distal phalanges absent.

Left Foot: Dorso-Plantar View. Distal phalanges of hallux and 2nd, 3rd and 4th toes absent. Middle phalanges of 4 lesser toes absent. Heads of proximal phalanges of 2nd, 3rd, and 4th toes not developed. The osteology in the metatarsal and tarsal areas was normal.

Comment

The above is a distinct case of ectrodactylia, a congenital absence of toes or parts of toes, not frequently seen. These cases are congenital and some have been reported to occur in families.

The patient was dispensed an accommodative appliance for the tylomata and the extreme pes cavus condition. To date the patient is comfortable and the tylomata seem to be under control.

28 N. Jardin

"The great law of culture is: Let each become all that he was created capable of being."

Thomas Carlyle

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PRESIDENT'S PAGE

Improving and Broadening Our Educational Basis

No other profession has raised its standards of education so quickly as has ours, despite its relatively short existence. This has resulted in the acceptance of us, by the public at large and by public and private agencies and organizations, as a responsible profession. However, we must continue to broaden our educational requirements without necessarily increasing the time span, but by improving the quality. Unless we wish to be relegated to the category of "technician" there must be improvement in basic preclinical science teaching in our schools as well as broadened clinical programs.

This requires money and "know-how."

The report of the Fund for the Advancement of Podiatry-Chiropody Education, including the reports of the fund raising programs of our individual schools and their Alumni Associations, presented in the January issue of our Journal, is very heartening. It indicates an awakening of the profession to its responsibilities in this regard. But this is just a beginning. I urge all of you who have participated to increase your efforts and would demand, if I could, that everyone contribute a fair share.

There are many opinions as to how we should improve our educational program. Which subject or subjects need "shoring-up," which broadened, which should have more depth? What new personnel is needed? Should some be replaced? What physical facilities not presently available should be acquired? How much of our teaching program can be given at neighboring universities and colleges under contracts? And where should we start? The answers to these questions require examination and evaluation by objective, unbiased experts.

Our 1959 House of Delegates has wisely seen that a very major share of the funds that will become available, starting June 1, 1960 through the raise in dues structure, is to be used for these purposes. We are all confident that the Council on Education, the "Fund," and the Board of Trustees will assure our continued growth in the service of the public.

MARVIN W. SHAPIRO, D.S.C.

SOME THOUGHTS ON SURGICAL JUDGMENT

In the surgical clinics of North America, H. Laufman has presented some very cogent thoughts of the duties of the surgeon with respect to the exercise of his judgment. The content of this paper is of interest to all of us and is here presented.

All therapy is designed to prolong life and alleviate suffering. The decision for or against surgical intervention in any given case depends upon the accumulation of pertinent data derived from a careful history, physical examination, diagnostic laboratory findings, and the surgeon's "feel" of the case. He considers, if intervention seems advisable, whether it is feasible in terms of risk to the patient, and how a proposed operation can be modified to fit the set of circumstances. A surgeon's decision may be influenced by eagerness for experience, by his own psychologic and financial needs, by the preference of the referring physician, and by the patient's urgent desire for the operation. Any motive not based entirely upon the patient's welfare violates the principles of surgical judgment.

Surgical intervention is necessary if (1) all information regarding the patient indicates he cannot improve within a reasonable time without an operation; (2) if without surgery the patient's condition may lead to complications or death; (3) if surgical intervention is necessary to obtain an accurate diagnosis which can lead to proper, specific therapy. The known risks involved must be weighed and a decision made regarding measures that will minimize those risks. These decisions govern selection of optimal time and place, course of preoperative care, type of anesthesia to be used, best anatomical approach, and how radical the surgery can be. The surgeon must consider possible complications and the probable outcome in light of the best results to be expected.

Familiarity with the literature and current statistics is helpful if selective, but cannot serve as substitute for judgment. There is no "average patient." Each patient, however minor his lesion, has his individual sensitivities, stresses and patterns which require consideration. Stereotyped thinking by the surgeon provides no preparation for unexpected reactions and events. Factors which can demand modification of a surgical procedure are: expectancy in relation to the disease; the urgency in preservation of life; concurrent, even unrelated, infirmities; evaluation of the patient's tolerance for variations in the procedure, and a knowledge of the particular goal to be sought. A well-disciplined surgeon responds to specific needs of the moment, whether ordinary or deviant, according to his experience and within the principles of sound surgical practice, but without undeviating adherence to rigid routine.

Rapport between surgeon and patient depends upon the surgeon's honesty. He tells the patient, without use of technical phrases or medical jargon, all that is pertinent to his condition, the treatment proposed, and its expected course as far as the patient can understand and accept emotionally. The patient's stresses must be accepted as normal, and his self-respect and dignity maintained.

Two types of fear beset the surgeon, rational fear which is a necessary tool of responsible surgery, and irrational fear which is unnecessary and dangerous. Rational fear is a realistic recognition of potential danger to a patient which keeps the surgeon alert before, during and after the operation. "It makes him

respectful of tissue, attentive to detail, swiftly responsive to subtle changes, careful to avoid complications." Fear sharpens "his skills so that he may avoid catastrophe and meet new problems flexibly when they arise." Irrational fear can be based on insufficient knowledge of the problem or inexperience in dealing with it. The surgeon in that case should ask assistance of a more experienced surgeon, or refer the patient to such a surgeon. A surgeon may fear criticism because the patient is considered "important," he may fear extensive procedures, and fear other members of the staff because of some disagreements. This type of fear can destroy motives, presence of mind and coordination—his surgical judgment is thereby weakened. Technical skill and surgical judgment are shown by his confidence in handling tissue, which is acquired in the experimental laboratory, at autopsy, and at operations. He has a sense of balancing strength and delicacy to be applied at any given instance—this is a surgeon's technic.

Surgical judgment is required in certain specifics of surgical management. He collaborates with the surgical team, but he is responsible to the patient at all times. He decides the type and mode of anesthesia to be administered, decides whether to proceed with the operation or to send the patient back to his bed without operation. On his decision rest all changes made in the planned procedure in cases of unexpected findings. He sees the patient through the postoperative period, coping with fluid and electrolyte balance, taking precautions against complications and keeps in touch with the status of vital functions through physiologic and laboratory examinations; he plans medications and ambulation; he encourages the patient to cooperate. Surgical judgment is constantly required.

A novel situation facing a surgeon may unexpectedly require a novel approach to old established technics. Variations in established procedures may come through knowledge of advances made in sister fields. However, some new procedure successfully performed by other teams of surgeons under controlled conditions, should not be eagerly accepted by an enthused surgeon who must work under uncontrolled conditions. New procedures must be perfected by repeated animal experimentations, and follow-up studies made to prove their value.

Surgical judgment comes from the physical, emotional, intellectual and moral capacities of the surgeon, from training and experience, and his potential to grow, learn and create, his ability to apply known principles to new specific situations and dedication to the patient's welfare.

STATISTICAL QUESTIONNAIRE

You should soon receive a copy of a questionnaire. We hope you will fill out the questionnaire as rapidly and as accurately as possible and return in the provided envelope addressed to Service Bureau Corporation, a subsidiary of International Business Machines, which will receive and tabulate all of the questionnaires. We anticipate that this will supply the association with much needed information about the profession, its members and its activities. We anticipate your active cooperation.

1960 White House Conference on Children and Youth

White House Conferences on Children and Youth have been a decennial tradition in America since the first was called in 1908 by President Theodore Roosevelt to discuss the plight of the dependent child. Every ten years the incumbent President has called a White House Conference to discuss the ever-widening facets of child-related problems and to recommend solutions.

From March 27 to April 2, 7000 persons concerned with children and youth will meet in Washington at the invitation of President Eisenhower to develop recommendations for citizen action programs to meet the needs of America's youth in the next decade. The delegates invited to represent the American Podiatry Association are Dr. Marvin W. Shapiro, President of the APA, and Dr. John T. Sharp, Chairman of the Children's Foot, Health and Youth Fitness Committees. The APA is a member of the Council of National Organizations on Children and Youth which is one of the three constituent bodies of the White House Conference. The other two groups to be represented are the National Council of State Committees for Children and Youth and the Interdepartmental Committee on Children and Youth.

Dr. Philip S. Barba, of Philadelphia, Chairman of the Committee on Program, has announced eighteen forum topics that will provide the framework for Conference discussion and that will deal with many problems anticipated in the rapidly changing world of the 1960s.

An entire forum comprising more than 500 people will be devoted to the problems of "youth in conflict," covering all phases of juvenile misbehavior: causes, diagnosis, prevention and rehabilitation. One forum will be devoted to the challenge of America's snow-balling mobility of population in relation to health, education, employment, social and cultural life of the young. Another forum will review the impact of the mass media on children and youth. Workshop discussions within this forum will deal with comic books and comic strips as well as radio, TV and motion pictures. Throughout the entire Conference a central concern for ideals and values runs parallel to the current national search for a redefinition of these same issues.

The following is a complete listing of the 18 forum topics:

THE WORLD AROUND THE YOUNG—

I. Environment—Social Conditions and Physical Facilities which Affect the Development of the Young

II. Mobility—Population Shifts and Changes in Health and Living Conditions, Education, Employment, and Social Situations which Affect the Young in the Community.

III. Support—Family Economic Conditions which Affect the Development of the Young

IV. Nurture—Family life: Attitudes and Practices in Child-Bearing and Child-Rearing

V. Opportunity—Freedom to Participate in Community Life and its Effects on the Young

VI. Free Time—Constructive and Non-Constructive Uses of Free-Time and their Effects on the Young

VII. Mass Communication—Trends in Media of Information, Entertainment and Culture which Affect the Development of the Young

VIII. Human Resources—Ensuring Necessary Services to Children and Youth through Effective Personnel

IX. Beliefs—Religious, Spiritual and Secular Beliefs and Personal Codes of Conduct which Affect the Development of the Young

THE YOUNG IN THE WORLD—

X. Moving Toward Maturity: Birth

to Puberty—Growth, Care and Training of Body, Mind and Emotions

XI. Moving Toward Maturity: Puberty to Young Adulthood—Growth, Care and Training of Body, Mind and Emotions

XII. The Young as Learners and Thinkers—Educating Each Child to his Full Potential

XIII. The Young as Doers—Involving the Young in Work and Responsibilities

XIV. The Young as Citizens—Involving the Young in Service to the Community and the Nation

XV. The Young with Mental Handicaps—Knowing, Understanding and Helping the Mentally Handicapped

XVI. The Young with Physical Handicaps—Knowing, Understanding and Helping the Physically Handicapped

XVII. The Young in Conflict—Knowing, Understanding and Helping the Maladjusted

XVIII. The Young with Social Handicaps—Knowing, Understanding and Helping the Socially Handicapped.

TAX CLINIC

HENRY KENT, C.P.A.
New York, N. Y.

Mr. Kent will conduct a regular column on tax problems for the podiatrist-chiropodist. Your questions may provide the basis for future columns.

EDUCATION EXPENSES

Every professional man is vitally concerned with keeping his professional skill and knowledge at the highest possible level. Very often that entails attending classes, conventions and professional workshops. Under the present Income Tax Law, education expenses undertaken primarily for the purpose of (1) maintaining or improving skills required in the taxpayer's profession, or (2) meeting the express requirement of taxpayer's employer, are deductible expenses.

Not all education expenses are tax deductible, and it is, therefore, very important that the taxpayer clearly understands the provisions of the Code. Let us start with education expenses that do *not* qualify as a federal income tax deduction.

If the education is primarily undertaken to obtain a new position or to obtain a substantial advancement in a position, or primarily for the purpose of fulfilling the general educational aspirations or other personal needs of the taxpayer, such expenses are *not* deductible. Furthermore, the costs of education to meet the minimum requirements for qualification in a taxpayer's *intended* profession or specialty therein are *not* deductible.

Here are two examples to illustrate a deductible and a non-deductible situation. Example (1) Smith, a general practitioner of medicine, takes a course of study to become a specialist in pediatrics. Smith's education expenses are *not* deductible because the course of study qualified him for a specialty within his profession. On the other hand, Jones, a general practitioner of medicine, takes a four-week course reviewing developments in specialized fields, including pediatrics, for the purpose of carrying on his general practice. Jones's education expenses *are* deductible because they were undertaken primarily to maintain and improve skills required in his profession.

At the same time, education expenses

that would qualify a taxpayer to obtain a license to practice a profession are not deductible. The cost of a license or an examination to qualify for the right to engage in a trade or profession is not deductible.

To summarize, education expenses are deductible if they are of a nature to improve or maintain existing skills but are not deductible if they are of a nature to learn a new profession or to qualify for a new (to the taxpayer) specialty in that profession.

Generally, expenditures for travel as a form of education are non-deductible personal expenses. However, if an individual travels away from home primarily to obtain education, expenditures for travel, meals, and lodging while away from home are deductible. However, if the trip combines education with some other unrelated personal business trip, an allocation must be made between deductible and non-deductible travel items. For instance, you (a self-employed practitioner) travel to X city, 500 miles away from your home to take a two-week refresher course in new developments in your profession. Your primary purpose in going to X city is to take the course, but while there you take a sightseeing trip to city Y (about 50 miles away) and visit some friends. Your transportation expenses to X city and return to your home are tax deductible, but the transportation expenses to city Y are not deductible. Your expenses for meals and lodging, while away from home, should be allocated between your educational pursuits and your personal activities. Of course, such expenses as sightseeing, entertaining your friends are entirely personal and non-deductible.

In addition to travel expenses (including meals and lodging while away from home), education expenses include tuition, books and laboratory fees.

Convention expenses, which are closely related to the taxpayer's profession, are tax deductible. Here again travel expenses including meals and lodging while away from home are deductible.

As with all tax deductions, proper record keeping will help to sustain the tax deduction. This includes, in addition to proof of payments of the various expenses, proof of the relationship of the education expense to the taxpayer's profession.

NEWS OF THE PROFESSION IN GREAT BRITAIN

FRANKLIN CHARLESWORTH, F.Ch.S.
Manchester, England

A regular series of "letters" about the profession in Great Britain, arranged for, or by Mr. Charlesworth, Editor of the British Chiropody Journal, will appear in this column.

Professions Supplementary to Medicine Bill

At the moment British Chiropody is facing a crisis. After more than a decade of stagnation it is now having to deal with a widespread upheaval affecting both the organization of the profession and the conduct of private practice. The changes envisaged are so profound that there must be a complete rethinking of all our problems if the future of chiropody is not to be spoiled.

For years we have been clamouring for legislative protection and for the inclusion of more chiropody in our Health Service and now both are being thrust upon us very largely in a manner we do not like.

It is said the British have a genius for

compromise but we probably have a greater genius for improvisation. Most of our institutions have grown from needs that have been met piecemeal as and when necessary. Only at a later date have these improvisations coalesced into a coherent whole. By then they have threatened to get out of hand and some sort of integration was the only way to avoid chaos. It seems this is just what is happening with Chiropody as well as with the other professions included with it in a Bill now before Parliament.

This is called the "Professions Supplementary to Medicine Bill" and includes all the professions such as chiropodists, dietitians, medical laboratory technicians, occupational therapists, physiotherapists, radiographers, remedial gymnasts and speech therapists, which we used to call medical auxiliary.

The purpose of the Bill is, to quote the preamble; "To provide for the establishment of a Council, boards and disciplinary committees for certain professions supplementary to medicine; to provide for the registration of members of those professions, for regulating their professional education and professional conduct and for cancelling registration in cases of misconduct; and for purposes connected with the matters aforesaid."

The passage of such a Bill through the House with all the preparation it entails is quite enough to have on hand at one time. Unfortunately and for good measure the Minister of Health preceded the introduction of this Bill by announcing some months ago that he was prepared to extend the amount of chiropody permitted under the National Health Service. He announced plans, made apparently by himself or his advisors, without prior consultation with the chiropody organizations to open chains of clinics throughout the country.

Here I must digress to explain one or two points about our Health Service. It is administered in three parts. The hospitals have their own administration and are one part of the service. The second part consists of a series of County Executive Medical Committees which administer that part of the service which comprises the doctors in general practice, the dentists and the opticians. The third part consists of the Health Committees of the local Borough and City Councils who look after Public Health, the School Health Service, the Ante-natal clinics and the Welfare Services for the aged and infirm.

The general idea is to put the general practice of medicine and everything connected with it such as the pharmacy prescription service, the testing of eyes and care of teeth under the administration of these medical executive committees and for measures designed to prevent illness to be put under the local health committees and their medical officers of health. Since the extended chiropody service is, in the first instance, to be restricted to old people, the physically handicapped and expectant mothers, it is included in the measures designed to prevent illness and so comes under the jurisdiction of the Local Health Committee and its Medical Officer of Health. The Minister of Health did this without consulting any of the chiropody organizations at all. This means that chiropody will now have to be done in clinics under the local Medical Officer of Health.

It may not be without political implication that the Minister announced this provision of chiropody treatment just before a General Election but I believe he was genuinely surprised when we protested that patients should be seen in private surgeries on a fee per treatment basis rather than in clinics. At any rate he compromised to the extent of permitting the Local Health Committee to arrange for patients to be seen in private surgeries if they thought it necessary or desirable. So far very few committees have thought that way and consequently nearly all the work will

have to be done in clinics. Chiropodists will be employed on a basis of so many three hour sessions per week to begin with and later on a full time basis. This will make for a salaried chiropody service and is the last thing many of us want, for if the provision of chiropody as a National Health Service treatment is extended to cover the rest of the population it will spell the doom of private practice.

One would imagine the reasonable thing to do would be to get the profession registered and protected first with proper legislation, then to see about providing the service on a proper basis. Such seems to be our genius for improvisation that the extension of the service was carried out first and registration of the profession afterwards. Even this registration has not been carried to its logical conclusion for there are in this country some thousands of chiropodists who have been able to establish themselves in practice with only correspondence course diplomas because there has until now been no recognized legal standard. Even now the Bill does not propose to do anything about these people nor about the correspondence schools which are still turning them out except to refuse them employment in the Health Service.

This is the unsatisfactory state of affairs with which we are faced. There is no doubt about the next two objects for which we must fight. The first is to get administration of Health Service chiropody removed from the control of the Medical Officers of Health and into the hands of the Medical Executive Committees. Only then will chiropodists be able to see their health service patients in their own surgeries.

This will be a hard battle for it is a more expensive arrangement than running clinics but it has already put the dental and ophthalmic professions on the road to success. The second is to sponsor further legislation directed this time to the control and ultmate extinction of the correspondence qualified chiropodist.

L. C. Gibbard, M. Ch.S.
Senior Lecturer
The Manchester Foot Hospital
School of Chiropody

AWARDS FOR RESEARCH PAPERS

On page 153 of this issue will be found information regarding awards for research papers for this year. Authors of award winning and other selected papers are invited to read their papers at our Annual Meeting. May we suggest that you write now for an application form, rules and regulations, and not wait for the last moment?

"Slow me down, Lord and inspire me to send my roots deep into the soil of life's enduring values, that I may grow toward the stars of my greatest destiny. Amen."

Unknown

FORTY-EIGHTH ANNUAL MEETING

Drake Hotel, Chicago, Illinois
August 25 to 30, 1960

CHICAGO, the great air-conditioned city on Lake Michigan, will be the site of the 1960 A.P.A.–N.A.C. Annual meeting. Your headquarters will be the beautiful Drake Hotel, situated so conveniently for the many attractions that make Chicago the convention and vacation center of America.

You and your families will be intrigued by the "Magnificent Mile" on fabulous "Boul. Mich." where the Drake Hotel is located. This glamour strip of shops leads into the Chicago Loop, famed for its Department Stores, Theatres, and fine Restaurants. Just a step away on the Lake Front is Grant Park, containing the spectacular Buckingham Fountain, Art Institute, Shedd Aquarium, Chicago Museum of Natural History, and the Adler Planetarium. A short bus ride to Jackson Park will bring you to the Museum of Science and Industry, magnet to millions of visitors, and soon to house the PODIATRY exhibit. To the north of the Drake is Lincoln Park where you can visit the famous Zoo and Conservatory. For Sports fans there is always Major League Baseball and Horse Racing.

Your Scientific Committee, led by co-chairmen Drs. DuVries and Reisgraf, is working hard to make this the most worthwhile of meetings. We will begin Saturday, August 27th, and continue Sunday, Monday and Tuesday, with interesting and practical sessions.

For the first time "Instructional Breakfast Courses" will be held. These have been highly successful in other medical meetings of this proportion. Workshops will be held for you in Shoe Therapy, Ortho-digital work, Casting and Strapping techniques, Pre and Post Operative Surgical care, treatment of Nail Dyscrasias, Injection and Su-

GRANT PARK ON THE SHORE OF LAKE MICHIGAN

Chicago's Front Door—Built entirely on land reclaimed from Lake Michigan, this mile and a half long show place is one of Chicago's most magnificent vistas. Already included in its facilities are a great yacht basin, an outdoor concert amphitheatre, a seaplane base, and a variety of recreational features, the Park's latest asset is an immense underground public parking garage. Few cities in the world boast as magnificent a front door as Chicago with its 29 miles of shoreline along Lake Michigan. The stretch shown here forms the eastern border of the city's main business district.

CHICAGO'S MAGNIFICENT MILE

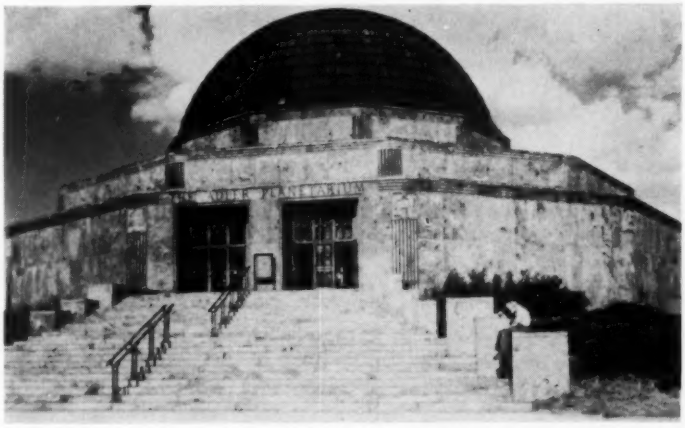
The busy highway shown crossing the Chicago River to carry its traffic into Chicago's Gold Coast area is known as "The Magnificent Mile," one of the most valuable stretches.

turing techniques, and other "down-to-earth" material. This will be a robust program, but will be arranged that main programs will not conflict with the workshop courses.

A Geriatric Symposium in conjunction with President Eisenhower's "White House Conference on Aging" will be a highlight of the scientific program. Be sure YOU attend and learn what is being done across the nation to care for and rehabilitate our aging population, and where Podiatry/Chiropody stands to gain and accomplish BIG things in this phase of our work.

Monday and Tuesday will be given over to programs on Dermatology, Orthopedics, Surgery, Rehabilitation, Radiology, Peripheral Vascular and Neurological aspects of our profession. Podiatric Medicine, emphasizing Hematology, the Edemas, and Neuropathies, will be offered.

There will be time in between sessions to visit exhibitors, scientific exhibits, and to relax and enjoy yourselves with your friends. SEE YOU IN CHICAGO IN AUGUST!



ADLER PLANETARIUM

Adler Planetarium on Chicago's lakefront at Roosevelt Road was the first Astronomical museum ever built in America. Here daily thousands witness demonstrations explaining all the mysterious workings of the celestial orbit. Other very interesting educational museums in the area are: the Museum of Natural History, Museum of Science and History, Chicago Historical Museum and Chicago's World-Famous Art Institute. Also of major interest in Chicago are the Lincoln Park and Brookfield Zoos and the Shedd Aquarium.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

pantho-Foam

Description: Hydrocortisone 0.2% and pantothenylol 2.0% as an aerosol foam.

Action and Uses: Exerts the inflammatory-suppressive, anti-pruritic, antiallergic effects of hydrocortisone plus the soothing, antipruritic, healing influence of pantothenylol for prompt relief from pain, itching and inflammation in burns, traumatized lesions, stasis ulcers, atopic dermatitis (eczemas, neurodermatitis, etc.), contact dermatitis (poison ivy, etc.), pruritic lesions (anal, vulval, etc.). Non-occlusive, so lets skin "breathe." Non-traumatizing—applied directly to skin.

Application: Apply two to three times a day, or more often as needed.

Supply: pantho-Foam, 2 oz. aerosol container. By U. S. Vitamin & Pharmaceutical Corp., New York, New York.

Podivite

Description: A multiple-vitamin-mineral formula in soft gelatin capsules containing eleven vitamins — both oil- and water-soluble — plus ten minerals.

Advantages: A broad spectrum of essential nutrients in only one easy-to-take capsule. Deficiencies of a single vitamin are rare; almost without exception, they are multiple. The interrelationships, interdependence, and synergism of vitamins and minerals are the most important aspects of their proper functioning, and the wide scope of the Podivite formula assures the patient of the full benefits of these principles.

Action and Uses: The function of the capillary system is to deliver essential nutrients to all tissue cells. When blood levels of these nutrients are consistently low, tissues throughout the body will react. Thus, vitamins and minerals, and other nutrients cannot be less vital to the lower extremities than to other constituent tissues. It has been reported that lesions of the lower limb which remain resistant to established treatment will often respond following adjunctive therapy with vitamins.

Indications: An adjunct to chiropodical therapy in those cases where lesions of the lower limbs remain resistant to treatment.

Dosage One capsule daily, or as needed.

Supply: Bottles of 60 capsules. By PodiatRex, Ltd., Glendale, California.

Normacap

Description: A synergistic compound providing therapeutic dosage of vitamin C, citrus bioflavonoids complex (vitamin P), and citrus pectinates, in tablet form.

Advantages: Vitamin C has long been established as playing a major role in the maintenance of normal capillary permeability. More recently bioflavonoids appear to be essential in the absorption and retention of the vitamin, increasing its biological potency by as much as 200-300 percent by tending to catalyze the combining of vitamin C with protein to form the intercellular substance of the endothelial wall of the capillary. Through colloidal, chemical anti-bacterial properties, the pectinates remove irritants in the intestinal tract, thus enhancing the absorption of nutrients.

Action and Uses: While not a disease entity in itself, a disturbance of the capillary tree is now known to be often associated with many acute and chronic conditions. An impressive number of clinical reports and symposia have indicated that a weakness of the capillary bed may be overcome by the use of a compound of vitamin C and bioflavonoids.

Indications: Ecchymoses and petechiae, frequent nosebleeds, and other signs and symptoms of abnormal capillary permeability, very often secondary to atherosclerosis, eczema, hypertension, edema, hives, stasis dermatitis, rheumatic arthritis and other acute and chronic conditions.

Dosage: One tablet three times daily, or as needed.

Supply: Bottles of 90 tablets. By Podiat-Rex, Ltd., Glendale, California.

Soyaloid™ Colloid Bath (pH 5.75)

Description: Contains colloidal soy bean complex and 2% PVP (polyvinylpyrrolidone). Provides a protein-mantle, soothing bath for generalized acute dermatitis, etc.

Indications: Allergic dermatitis, pruritus, contact dermatitis, infant rashes, neurodermatitis, urticaria, bath itch, pruritus vulvae et ani, penicillin rashes, senile pruritus, and other non-specific, generalized skin conditions.

Administration: Colloid Bath, contents of one package to a tub of warm water. Infant bath, 2 or 3 tablespoonfuls to bathinette. Sitz, foot-or-hand-bath, 2 or 3 tablespoonfuls to each gallon of warm water. Local irritation, use as lotion—2 heaping tablespoonfuls to a cup of warm water.

Supply: Box of 5 packets, 3 oz. each. By Dome Chemicals, Inc., 109 West 64th Street, New York 23, N. Y.

Stan-A-Dome™ Creme

Description: New topical creme for restoring skin turgor in senile skin atrophy and ichthyosis. A water-in-oil creme containing 0.3 gm. dihydrotestosterone and 500,000 U.S.P. units synthetic vitamin A per oz. in the exclusive Acid Mantle® vehicle.

Indications: Senile skin atrophy, ichthyosis.

Administration: Apply a small amount to the skin and rub in lightly. Use 2 or 3 times a day. Caution: Use sparingly. Dihydrotestosterone is a potent androgen. If masculinizing effects appear discontinue use. Avoid use in patients with prostatic carcinoma.

Supply: ½ oz. and 1 oz. tubes. By Dome Chemicals Inc., 125 West End Avenue, New York 23, N. Y.

And from Socrates this, in free translation:

"Justice consists in helping every man to find his true place in life."

"It is for science not only to add years to life but, more important, to add life to years."

PODIATRY-CHIROPODY ABSTRACTS

JEROME SHAPIRO Pod.D.
5429 Connecticut Ave., N.W.
Washington, D. C.

Editors of Local, State and Regional Publications are requested to provide copies to Dr. Shapiro who is editing this section of the Journal.

A FOOT SURVEY OF STIRLINGSHIRE SCHOOL CHILDREN

C. Freebairn, M.Ch.S., The Chiropodist, 14:11, Nov. 1959.

An examination of school children in Stirlingshire, England was undertaken to determine the condition of feet and footgear of the students. The children were examined without warning. This was essential to certain parts of the survey such as cleanliness and footwear. The children were examined for defects of gait and posture and for presence or absence of tinea, hallux valgus, pronation, poor hygiene, genu valgum, improper footgear, nail conditions, corns, calluses, warts, orthopedic deformities, hyperhidrosis and hallux varus.

One thousand twenty-four children in all were surveyed and the statistical results are well reported in the article. For example, 52% of the girls presented some form of foot defect as opposed to 37% of the boys. Four per cent of the girls under five had corns. Fifty-four per cent of the girls in the 16 year and older group had hallux valgus whereas this was noted in only 14% of the boys. Hallux valgus was recorded when there was a 10 degree or more deviation from the line of the first metatarsal.

TREATMENT OF TINEA PEDIS AND TINEA UNGUIUM WITH GRISEOFULVIN: PRELIMINARY REPORT

L. M. Lindenberg, D.S.C., Current Podiatry, 8:11, Nov. 1959.

After a brief mention of the background history of griseofulvin, the author goes on to cite his experience with the drug. Twenty-eight patients with chronic fungus infection of the feet were put on griseofulvin. A clinical photograph was taken before starting each case and cultures were made to ascertain the organism involved. All patients were impressed with the importance of carrying out hygienic measures while receiving the drug.

The dosage was varied with the severity of the condition and was adjusted at intervals to maintain progress with the smallest possible dosage. It was noted that the duration of the treatment depended upon the thickness of the keratin in the area involved. Dorsal surfaces cleared in 3-4 weeks whereas the soles and heels took much longer and the nails the longest.

The findings reveal definite improvement in 25 of the 28 cases regardless of the extent of the chronicity. Wherever pruritus was a factor this disappeared after the first week of treatment. The only side effects reported were minor headaches in one patient and occasional GI upsets, none severe enough to warrant discontinuance of the medication.

DISTRIBUTION OF SKIN TUMORS OF THE SOLE OF THE FOOT

M. Levene, M.R.C.S., D.Path., The Chiropodist, 14:11, Nov. 1959.

This study of skin tumors of the foot was undertaken to find out if pressure contributed to the dissemination of the melanoma. The cases of the survey consisted of 511 lesions of the foot seen at Christie Hospital, Manchester, England. The lesions fell mainly into five categories: (1) squamous cell carcinoma, (2) melanomas, (3) malignant change occurring upon pre-

existing conditions such as burns, irradiated psoriasis, tabes dorsalis, (4) plantar warts and hyperkeratotic lesions, (5) angiomas.

The melanomas all appeared in the arch areas, as opposed to the squamous cell carcinomas and hyperkeratotic lesions which were on the metatarsal and heel areas. Tumors arising from pre-existing lesions were scattered indiscriminately. Unlike all the other lesions, the angiomas extended from the plantar to the dorsal surfaces and vice versa. This could be explained by the vascular nature of the lesion.

The squamous cell lesions were more commonly found in the males; the melanomas were more frequently seen in the female. The observations that the melanomas tend to occur in the arch site, where there is little weight bearing, suggest that much more will have to be learned before accepting pressure and irritation as the mechanism of spread, at least in the early stages of melanoma metastases.

THE MANAGEMENT OF INFECTED AND INFLAMMATORY SKIN LESIONS WITH A STEROID-ANTIBIOTIC COMBINATION

Leon Goldman, M.A., N.Y.S., Journal of Podiatry, 20:7, July 1959.

The presence or threat of bacterial infection is often a deterrent to the use of topical corticosteroids for the treatment of inflammatory and pruritic skin lesions. Since many common inflammatory skin lesions seen in the foot are complicated by secondary bacterial invasion, it becomes more efficacious to utilize a preparation that contains steroid and antibiotic properties combined. Herein is reported a case study of 18 patients with inflamed and infected skin lesions of the feet treated with a topical preparation containing a powerful corticoid (triamcinolone acetonide) in conjunction with the antibiotics, neomycin and gramicidin.

Fourteen patients showed excellent results while results were good in one and fair in the remaining three. None of the patients failed to respond to some degree and at no time were there any signs of systemic effects attributable to percutaneous absorption of the steroid component.

A STUDY OF TOENAILS

L. J. Friedman Pod.D., The American Podiatrist, 14:4, Nov. 1959.

The author presents the clinical appearances of varied human nail conditions such as: onychoschizia, onycholysis, onychomadesis, leukonychia, onychorrhexis, beau's lines, dystrophia mediana canaliformis, pigmentation, hippocratic nails, onychoheteropia, etc. Descriptions are also given of nail symptoms due to poisons, such as: silver, arsenic, aniline, lead, mercury, thallium, acetanilid and gold.

"It is a comfort that the medal has two sides. There is much vice and misery in the world I know; but more virtue and happiness, I believe."

Thomas Jefferson

BOOK REVIEW

PRACTICAL NEUROLOGY

Leo M. Davidoff, M.D., professor and chairman, Department of Surgery of the Albert Einstein College of Medicine. Director of Surgery, Bronx Municipal Hospital Center, Chief of Neurosurgery, Mount Sinai Hospital, New York, N. Y., and Emanuel H. Feiring, M.D., Associate Professor of Surgery, Albert Einstein College of Medicine; Visiting Surgeon, Bronx Municipal Hospital Center; Associate Neurosurgeon, Mount Sinai Hospital, New York, N. Y. 442 pages. The Blakiston Division of The McGraw-Hill Book Co., Publisher, N. Y. 1957.

This book is intended for the physician engaged in general practice as a concise clinical reference guide in neurology. The wide experience of the authors is exhibited in their handling of the subject matter.

The book is academically good reading for the podiatrist. The neurological normal of station and gait is worthwhile knowing. In reflex examinations the authors state that it appears to be easier for patients to relax their upper extremities than their lower ones. The mechanism of performing an adequate ankle clonus is fully described in a practical fashion. The authors tell us that the most important superficial reflex in neurology is the response of the toes to plantar stimulation. The Babinski sign is described in full detail. In Chapter III on vascular diseases of the nervous system, lower limb dorsiflexion of the toes and foot, eversion of the foot and flexion at the hip and knee are most defective in cerebral thrombosis; inversion of the foot and extension at the hip and knee are least weakened. Chapter IV describes Trauma of the Nervous System. The Sensor loss of the sciatic nerve is demonstrable over the lateral surface of the lower two-thirds of the leg, and over the sole and dorsum of the foot, exclusive of an area along its medial aspect. These details are very interesting to the storehouse of information. In Chapter V the authors described cases of congenital heart disease, where an abnormal communication exists between the right and left side of the heart, an infectious process in any part of the body may permit the passage of septic material directly to the brain without being screened in the pulmonary circulation. Thus in patients of this sort the occurrence of an expanding brain lesion after infection, even of a toe, should lead to serious consideration of a brain abscess. This was news to me and of course worthwhile reading. The authors report the observation made in a number of cases of spinal cord tumors, especially in the upper cervical region, of a feeling of coldness of the feet often of an extreme degree "as if the feet were packed in ice."

While this book will not increase the efficiency of the practical workday in most of our offices it is worthwhile reading. It can be said that this book shows us what the neurologist looks for in his examination of the foot and leg. It is a study that is head and shoulders above much of my reading. This book is recommended as an authoritative source of academic reference of a very complex study.

S. M.

The man wrapped up in himself makes a pretty small package.

Ivefor Gotten

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

ARTHRITIS; RHEUMATIC DISEASES

The Pre-eminent Role of Vitamin A in Rheumatoid Arthritis, Peripheral and Spinal, and in Psoriasis Vulgaris, T. Benedek. Acta rheum. scand. 4: 178-92, 1958.

Rheumatoid arthritis and psoriasis vulgaris have been proved by bacteriologic and immunologic evidence to be manifestations of the same etiologic and pathogenic principles. The causative organism in both is *B.* endoparasiticus, which exists in the blood, and which produces a bacterial-allergic inflammatory process due to autosensitization of connective tissue. The process is infectious, but not contagious. Psoriasis vulgaris does not exist as a separate entity. It is a manifestation of the permanent endoparasitism in the cutaneous and articular connective tissues.

Treatment of rheumatoid arthritis and psoriasis with the specific vaccine of *B.* endoparasiticus alone does not arrest the pathogenic processes. Three factors apparently interfere with the effectiveness of the specific vaccine in therapy of these two diseases: (1) an extreme deficiency of vitamin A, as shown by measurement of the vitamin A level in the peripheral blood; (2) a dysfunction of the reticulo-endothelial system, as indicated by severe, continuous bacteremia of the *B.* endoparasiticus; (3) complete absence of antibody formation as a response to the specific antigen vaccine).

The normal level of vitamin A in the blood is considered to be 90 to 100 I.U. for females and 110 to 130 for males, and the critical level in general as 70 I.U. per 100 ml. of blood. In determining the vitamin blood level among 244 patients having psoriasis, 188 (77.1 per cent) showed an initial pretreatment vitamin A level between 10 and 40 I.U. In 59 cases of rheumatoid arthritis, 52 (80.6 per cent had a similar level. In 14 cases where rheumatoid arthritis and psoriasis occurred together, 12 showed a vitamin A blood level between 10 and 40 I.U. In no instance was the vitamin A blood level above 50 I.U.

The biologic interdependence between vitamin A blood level and the effect of *B.* endoparasiticus vaccine was shown during experimental treatment: (A) When the vitamin A blood level is at or above critical level (70 I.U.) the vaccine used alone appeared to be effective—but there are few such cases. (B) When the vitamin A blood level is below critical level while the specific vaccine is being given, vitamin A should be administered parenterally. Oral medication with vitamin A is valueless, because it is not absorbed in the intestinal tract. (C) When vitamin A therapy accompanies vaccine therapy, one of three results will be noted: (1) The vitamin A blood level rises to or above critical level, and arrest of the process is prompt and of long duration; or (2) the vitamin blood level increases by small increments, but fails to reach the critical level, even if given parenterally. The effect is slow but progressive; arrest is of short duration, and recurrence is frequent; or (3) the vitamin A blood level remains practically unchanged whatever amounts of vitamin A are given parenterally; remission is minimal or partial. Total arrest is not accom-

plished. This is considered due to lack of, or to defective production of, gamma globulin. (Ed. Note: Special vaccine obtainable only from the author at the Stretch School of Medicine, Loyola University, Chicago, Ill.)

DERMATOLOGY, ALLERGY AND FUNGUS DISEASES

Proteolytic Debridement of Hyperkeratoses of Palms and Soles, D. N. Mulay and F. Urbach. Arch. Derm. 78: 758, 1958.

In three cases of very severe hyperkeratoses of the palms and soles, proteolytic debridement was performed. The palms of both hands and the soles of both feet were immersed for periods of approximately 30 minutes in a 30 per cent solution of commercial urea powder in water. This caused the keratoses and cutaneous horns to become whitish and translucent and the surface soft and slippery. Surface keratin was carefully removed with a sharp scalpel. This was repeated twice a day until all thick keratin was removed. Rough spots remaining were gently planned with a wire brush. The procedure, taking about 4 to 5 days, was painless and brought marked relief from discomfort.

Vioform-Hydrocortisone Cream in Selected Dermatoses, D. G. W. Brookings and J. B. Howell. Texas State J.M. 54: 792-95, 1958.

Vioform (3 per cent) -hydrocortisone (1 per cent) in a water washable cream was used topically in treatment of 34 patients with various types of dermatoses.

Nummular eczema was treated in 8 patients. In this eruption pinhead-sized papules and papulovesicles group together to form coin-like plaques, with remission in summer and exacerbation in fall or winter, or the opposite may be true. Vioformcortisone cream is not curative, but is suppressive. It is applied one to five times or more each day, according to severity of the disease. It afforded prompt relief from severe itching and discomfort in all 8 cases and the eruption cleared. The eruption recurred when the treatment was discontinued. Remission might last for 5 to 7 days.

Dermatitis eczematosis of the hands was treated in 24 patients with the cream. This group of patients apparently suffered from an alkali type of eczematous eruption. They were instructed to reduce exposure of their hands to irritants by decreasing the number of hand-washings, dish-washings, and household chores. The vioform-hydrocortisone cream relieved itching, promoted healing, and acted as a mild bacteriostatic drug. Atopic dermatitis with alkali damage added is benefited by use of this cream. Vioform-hydrocortisone cream proved more helpful than hydrocortisone lotion, a 1 per cent tar paste, or hydrocortisone ointment. It is not a cure for eczema of the hands, but is one of the most helpful medications being used as topical treatment of this disease.

Lichen simplex chronicus (localized neurodermatitis) was treated in 10 patients with vioform-hydrocortisone cream. It controlled the itching, scratching and rubbing. It healed traumatized areas, some involving the instep or ankle areas, and it supported flow of venous blood. Its topical use acted as a "medical splint." In some patients roentgenotherapy was given along with medication to control itching —three to four treatments of 75 r each. It is suggested that a greater number of roentgen-ray treatments would have been required if vioform-hydrocortisone cream had not been used.

Seborrheal dermatitis was treated by daily application of the cream. The hair has to be covered if gray, to prevent staining. With clearing of the eruption, treatment can be stopped permanently, or until remission occurs. The cream showed its

greatest usefulness in treatment of 20 patients with this disagreeable dermatitis.

Atopic dermatitis in 15 patients, infants and adults, was controlled, not cured by this topical therapy; control was excellent in 10 of these patients. Where large areas were involved, its usefulness was limited.

Psoriasis of the hands treated with vioform-hydrocortisone for 6 weeks brought slow, gradual improvement. Remission occurred after use of tars together with ultraviolet light. Psoriasis of the anogenital area, complicated by moniliasis, responded to Myocostatin suppositories; a combination of vioform-hydrocortisone cream plus roentgenotherapy then brought remission. Another woman with psoriasis of the anogenital and umbilical areas obtained remission by use of the cream.

In the total group of 84 patients treated with the cream, no irritations nor allergic eczematous contact dermatitis resulted. Its disadvantage is its mild staining quality.

Moses, the First Dermatologist, A. A. Friedman. Sinai Hospital J. (Baltimore), 7: 41-43, 1958.

The Bible contains a vast amount of medical knowledge, including a large amount of dermatologic information and descriptions of scientific procedures as related in the ancient Mosaic Laws. The earliest detailed information is found in the Five Books of Moses which contain the teachings of Moses and his directions to the priests who served as health officers in guarding the health of the community and in preventing epidemics.

Clinical descriptions of contagious and noncontagious diseases are clearly given. The third chapter of Leviticus differentiates between noncontagious skin diseases and contagious dermatoses, such as leprosy. Chapter 13 describes pigmentary diseases and distinguishes between the prevalent disease of leprosy and vitiligo (bohock) which is a harmless lesion. Symptoms of leprosy are clearly described. The priests are directed to carefully examine every kind of lesion to determine whether it is a contagious one.

Hair diseases—senile alopecia, alopecia areata, and leprosy of the scalp—are clearly defined. A hair disease is described which is a type of impetigo or folliculitis and its contagiousness differentiated from other types; it may have been the pemphigus of today. Information regarding venereal disease, especially gonorrhea, of Moses 3,000 years ago, is scarcely improved upon now. Details regarding contagion by way of furniture, clothing, etc., and the disinfection methods to be used are excellent. Moses also had considerable knowledge concerning allergic disorders, and the cutaneous and respiratory diseases produced by airborne elements. He describes the Egyptian Plague as a pollen dermatitis in the ninth chapter of Exodus.

MUSCULOSKELETAL DISEASES

The Free Achilles Reyex in Hypothyroidism and Hyperthyroidism, J. D. Lawson. New England J. M. 259: 761-64, 1958.

The speed of tendon reflexes in correlation with thyroid function has long been realized, but recording methods have been technically inadequate and unsuited to office practice. The Kinemometer, an instrument devised by the author, when used with a standard electrocardiograph, records the unhindered Achilles reflex, showing speed patterns of movement as well as directions of movement. Time, speed, and direction patterns of reflex responses can be recorded in one to three minutes as a simple office procedure.

The Achilles tendon reflexes were recorded in 595 patients who had been referred by clinicians after making a diagnosis. Of these, 550 were found normal, 24

hyperthyroid, 21 hypothyroid. One finding, contrary to expectation, was that the contraction, and not the relaxation phase correlated with the thyroid status. A high degree of discrimination was observed between hypothyroid and euthyroid patients. Another observation was that in patients being appropriately treated, a progressive return to normality occurred. Furthermore, in hypothyroid and hyperthyroid patients patterns of response to certain medications differed considerably from the responses of normal persons.

Duration of muscular contraction in normal subjects was found to be shortened by several drugs such as, salicylates in large doses, dextroamphetamine sulfate, ACTH, cortisone, thyroid hormones and estrogens in high doses. The reflexes were lengthened in normal subjects by drugs such as thiourea compounds, perchlorates, and bromides in high doses.

A considerable variation was noted in the interval from stimulation to the end of contraction: from 120 to 240 milliseconds in normal subjects, 108 to 156 milliseconds in hyperthyroid patients, and 236 to 360 milliseconds in hypothyroid patients. No significant changes occurred in other pathologic conditions.

The study indicated that a large field of investigation regarding reflex responses remains unexplored.

Importance of the Rotators in Stabilizing the Knee, F. J. Ripley. Physiotherapy 44: 232, 1958.

The hamstrings, working unilaterally, are responsible for rotation when the knee is bent. The biceps femoris, inserting into the lateral aspect of the fibula, rotate outward while the semimembraneous and semitendinous muscles, inserting into the medial aspect of the upper part of the tibia, rotate inward; together they act like reins on the bent knee. In cases where the knee requires strengthening to withstand trauma, the usual practice is to concentrate on the quadriceps muscles, in the belief that they play a major role in stabilizing the knee.

Study of the mechanics of the knee shows that the quadriceps can not safeguard the vulnerable rotational movement. Since these muscles converge to form a common tendon which passes between the condyles of the femur to insert centrally on the front part of the tendon, the tendon resembles a rope passing over a pully when the knee is bent. Thus the quadriceps above the bent knee act like reins uniting in a single strap and attached to a horse's head.

Two exercises are described for the rotators. For training the hamstrings to work laterally, the patient is half-lying, with the thigh abducted and resting on the couch and the leg overhanging. With the operator supporting the foot and holding it in cupped hands, the patient tries to rotate the knee one way and then the other against resistance. This exercise will not cause displacement of the cartilage nor produce excessive pain as the contractions are partly static if the foot is thus anchored. The second exercise is for strengthening the hamstrings so that they hold the knee on a firm rein: the patient lies prone and bends the knee against manual resistance applied at his heel or by a weighted boot.

Orthopedic Conditions Associated with Childbearing, P. Rhodes. Practitioner 181: 304-17, 1959.

Anomalies of the skeletal system, unnoted because of normal compensation, may be revealed during pregnancy because they become accentuated and lead to symptoms. Muscle tone is lessened, ligaments tend to become softer and relaxed and may not return to normal following delivery, because of inadequate rest after the birth.

Common disorders occurring in various parts of the body during pregnancy are described.

Backache, one of the commonest complaints, is largely postural in origin. It usually disappears during the puerperium but often returns one or two months after delivery. Differentiation is necessary between pelvic and postural disturbances. The chief sites of postural backache are the lumbo-sacral joint, the sacro-iliac joints and the sacro-coccygeal joint. No radiologic, neurologic or pelvic findings of abnormality are noted in examination of postural backache. Exact diagnosis is obtainable by reproducing the symptom by appropriate manipulation of the back. However, during pregnancy, full manipulative measures and radiologic examination are not recommended.

Other orthopedic conditions arising or increasing during pregnancy include prolapsed intervertebral disc, congenital anomalies of the lumbar spine, pelvic osteoarthropathy, multifidus syndrome, and lower limb pains. Pain in front of the hip, occurring during pregnancy, may be caused by the stretching of structures anterior to the joint. With lordosis there may be some degree of pelvic rotation; when the pelvis is thrust forward in advance of the plane of the ankle joints the hip joints are held at the extreme of extension. Sitting brings relief from the pain.

Meralgia paraesthetica, a numbness, tingling or pain in the tract of the lateral femoral cutaneous nerve, or a dull sensation in the middle third of the outer side of the thigh, may result from pressure on the nerve roots by a prolapsed disc, or on the nerve where it splits the inguinal ligaments, or in the tunnel for the nerve in the fascia lata. Symptoms usually are not severe and disappear in the puerperium, but occasionally the disability persists. If pain continues a neurologist should be consulted. Flat feet often become worse during pregnancy. Use of appropriate footwear and exercises is helpful, since flat feet can cause multiple postural adjustments in the knees, hips and spine. The cause of pain may be sought in those areas instead of the feet which are the primary cause.

Foot-drop may follow normal or instrumental delivery as a result of interference with the function of the lateral popliteal nerve, and produce weakness or paralysis of the dorsiflexors of the foot, with numbness and paraesthesia on the outer side of the foot. Or acute prolapse of an intervertebral disc may cause pressure on the nerve; such pressure may be produced by forceps or by the fetal head in the pelvis. An orthopedic surgeon may need to be consulted. The principal treatments used are: (1) adequate splinting to prevent stretching of weak or paralyzed muscle, (2) maintenance of muscle tone by active exercises, (3) prevention of curvature and equinus deformity by full passive movements of the affected joints twice a day, (4) massage and faradotherapy, to maintain tone. Rheumatoid arthritis usually improves during pregnancy; it is suggested that this is due to increased secretion of cortisone.

NEW GROWTHS

Plantar Warts: A Simple Method of Treatment, W. W. Gunther. Australian J. Dermat. 4: 147-48, 1958.

Plantar warts in 169 patients were treated over a 5-year period; 102 had single lesions, 16 had 2, 11 had 3, and 29 had multiple lesions; 11 were of mosaic type. Sixteen were treated with fractionated x-rays and the remainder with a paint. Seventy-nine responded to the paint therapy in an average period of 2 months; pain disappeared in 7 days; 44 failed to complete the treatments. The 19 who showed improvement after one month of therapy, and did not return, may have been cured.

The 17 who showed no improvement after 3 months were then treated by fractionated x-rays. Failure followed use of paint, x-rays, and local therapy in 6 cases.

The patients were instructed to bathe the wart night and morning in 1 to 5 thousand lukewarm solution of potassium permanganate, to macerate the wart; then paint the wart night and morning and pare the wart whenever the skin became hard (usually about the third day). The formula of the paint used is brilliant green 0.5, formalin 30, resorcin 15, butyl alcohol 10, acetone ad 100 per cent.

Cures which followed were: by painting in 79; by x-rays in 16; by paint plus x-rays 17. Twenty-two patients had been treated previously—7 by x-ray, 1 by injection of an anesthetic, 1 by surgical excision, 4 by cryocautery, 9 by diathermy, without cure; all responded to this new regime.

Plantar Wart Treatment with Ultrasound, H. Kent. Arch. Phys. Ther. 40: 15-18, 1959.

A preliminary report is presented of the use of ultrasound in treatment of nine cases of plantar wart—a study made to determine the validity and usefulness of this procedure, and to encourage further investigation. A Birtcher Ultrasound Model No. 105-F with a frequency of one megacycle was used. The technic used brought no complaints regarding heat effects or pain. Five minutes after treating exquisitely painful warts, relief was obtained. Two patients had multiple warts; the others had single, discrete recent warts.

In this series, especially warts of long duration, the surface layer of cells had to be removed before the wart could be effectively treated. Paring the wart does not influence the course with ultrasound, but does make tissues increasingly sensitive. Patients with single warts which had been treated with x-ray showed loss of the outer keratinous layer over the wart, and upon removal the wart became elevated above the surrounding skin. This effect is opposite to that seen in warts treated by ultrasound. This elevated tissue is painful and must be abraded down with emery paper. Caustic agents (for example, podophyllin) produce cellular tissue changes, but with ultrasound normal skin cells are unaffected while the wart cells are destroyed.

The advantages of using ultrasound in treatment of plantar warts are relief of pain, no paring required, no destruction of skin, no scarring; no protective pads are required, and it is a painless procedure and can be administered on out-patient basis, with the patient ambulatory. Also, single warts in difficult position can be treated. The whole procedure is simple and effective; there are no recurrences. The disadvantages are the multiplicity of lesions and their prior treatments. X-ray and podophyllin seem to impair their response to ultrasound. The fact that ultrasound waves produce localized change, with necropsy of the wart without affecting the normal tissue, may be due to a vascular, molecular or viral effect, or two or more of these factors simultaneously. Further study is required to determine the changes produced. The method is effective in 90 per cent of cases.

ONYCHOLOGY

Ingrowing Toenail, L. T. Cotton. Practitioner 181: 350-54, 1958.

Since an ingrowing toenail may cause painful disability for weeks or months, an understanding of its anatomy and abnormal growth may be valuable in planning relief of pain and to prevent ingrowth of the nail and septic complications. The ingrown toenail, often less curved than usual in its transverse plane, is deeply embedded in the nail groove on one or both sides. A sharp spicule of nail may project from a corner and grow deeply into the

sensitive groove. With continuous irritation by the edge of the nail, the groove becomes inflamed and eventually suppurates, and granulation tissue forms along the side of the nail. Finally the nail may become loosened by pus, and paronychia develop.

Ingrowing toenails form most commonly in the second and third decades and in either sex. Usually the great toes are affected, but the second toes may also be involved. The outer edge of the nail is more often grown in than the inner edge. Usually both great toes are affected. The cause may be ill-fitting shoe; pressing of the toe down during walking so that the soft tissues ride up around the nail; the corner of the nail left sharp after being cut becomes embedded in the nail groove, or, more important, is cutting the nail too short at the free edge of the nail.

Prophylactic treatment consists of proper cutting of the nail: the terminal edge is cut transversely to its corners, leaving no sharp spicules, and cutting the nail long enough to project free of the grooves. Various means are used to prevent infection of an ingrowing nail: paring down the center of the free border of the nail, or cutting out a V-wedge to decrease pressure on the lateral edges; or a strip of thin metal foil is laid deep to the edge of the nail, in the nail groove, to protect the skin beneath the edge of the nail. A spicule should be removed by lifting the nail edge free of its groove, then cutting, proximally and obliquely, the sharp splinter. The procedure should be repeated regularly until the free border of the nail projects clear of the nail groove. This must be done by the chiropodist, not the patient, or the nail may grow in again.

When pus is present, the only satisfactory therapy is removal of the nail. Local anesthesia by use of a ring block is safe unless the inflammation extends beyond the distal interphalangeal joint. Lignocaine (2 per cent) is injected into the dorsum of the toe on one side of the midline, then the other, until the subcutaneous tissues are firmly distended. One blade of a pair of forceps is inserted beneath the nail on the side of the infection, the forceps are closed and rotated to avulse the nail. Cetrimide is used to cleanse the nail bed and an adherent paraffin gauze dressing applied. In 4 to 5 days the patient walks with a light dressing in a broad soft shoe.

Radical treatment is advised if a nail has been removed two or three times or if a chronic sepsis exists. The nail must be removed and further growth prevented by partial excision of the nail bed may be required, to prevent formation of horny excrescences in the area of the matrix. The nailfold and germinal matrix of the lunula are removed down to the bone. The operation is performed in a hospital under general anesthesia. Covering the raw area by a partial-thickness graft is recommended. Hemiphalangectomy, in which the distal half of the terminal phalanx is "filleted" out of the pulp of the toe and amputated, produces an excellent, though somewhat unsightly result. Because of rapid healing, it is recommended for the aged patient.

ONYCHOLOGY

Onchomycosis Due to Microsporum Gypseum, S. A. Rosenthal, D. Furnari, and J. A. Tolmach. Arch. Derm. 78: 759, 1958.

A rare case of nail infection due to genus Microsporum is described. Two fingernails on one hand and one nail on the other were thinned, scaling and disintegrating. Scrapings showed fungous mycelia and M. gypseum. Treatment with an ointment containing salicylic acid 3 per cent and ammoniated mercury 5 per cent brought cure. When seen 4 months later, the nails looked normal and the mycologic examination was negative.

PHYSIOLOGY

Physiopathology of Immersion Foot, H. Montgomery. Naval Research Reviews, Sept. 1959, pp. 14-19.

Animal life is warmed by heat produced by basal metabolism, by the specific dynamic action of food, by voluntary activity of muscles, and by shivering. Cooling of the body comes from evaporation of water from the skin and lungs. Circulation of the blood, especially in the skin, increases heat conduction to or from the environment. The body has a remarkable ability to regulate these activities to avoid environmental dangers, so that many persons maintain a constant body temperature regardless of fluctuating temperatures.

Any peripheral part of the body, such as the foot, is directly influenced by cold, since conduction of heat is small in relation to the surface of the part, but the circulation contributes heat to the exposed part. The clinical features of immersion foot are coldness, numbness and swelling of the foot after it has been immersed for several days in chilling water. Individuals vary greatly in their reaction susceptibility to immersion foot. Some suffer greatly after brief immersion in icewater, while others have little discomfort after immersion for several hours. Though rewarmed in the air at room temperature, the foot may be painfully inflamed for weeks after development of immersion foot. As inflammation subsides, the foot remains uncomfortable, with areas of anesthesia and local sensitivity to touch and to extremes of temperature. The foot may remain painful for years, but the blood supply remains intact and therefore gangrene does not occur.

As shown by experiments with animals, immersion foot is attended by signs of neuromuscular disability, including an inability to lift the foot at the ankle, to spread the toes, and to hop normally; also, anatomic changes can be seen in the leg muscles. Histologically, nerve and muscle are found to be altered, but without evident damage to the blood vessels.

Other experimental studies showed that after three hours of chilling, there was little or no impairment of the nerve action potential, and only moderate dysfunction of the muscle. Apparently, a partial block of transmission of nerve impulse occurs across the neuromuscular junction. Three days after this brief chilling, neuromuscular function is recovered, possibly due to subsidence of swelling, which allows redistribution of electrolytes; recovery begins within one month and is complete within 6 to 12 weeks.

These experimental studies indicated that immersion of an animal's foot for only short periods produces some lingering changes in nerve, in muscle, and in transmission across the neuromuscular junction. But, as in man, the brief exposure is not serious, since the changes produced are reversible. Longer exposure can produce permanent damage.

"Alone in power, supreme in grace
With the wings of an eagle, the voice
of a dove,
Outlasting death, and time, and space–
LOVE."

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

MINNESOTA

At the December meeting of the Minnesota Podiatry Association, a one day organizational and scientific meeting of the Minnesota Academy of Foot Surgeons was held. Its purpose is to effectively teach and foster good podiatric surgery by common interest and fellowship. Dr. Joseph Brennan, Dermatologist of St. Cloud, Minnesota, spoke on "Skin Diseases, Allergies and Skin Surgery." Dr. John Frankson moderated a panel on "Shoes . . . Their Origin, Construction and Effects on Human Posture and Locomotion."

Dr. Ed Tarara, as National Chairman of Podiatric Problems on President Eisenhower's program for the aged, proposed plans for the participation of Minnesota in the program. A campaign was launched to have podiatric claims honored by the health insurance companies in the State.

NEW YORK

The labor program launched by the New York Society got under way with picture stories in many of the largest union publications in the country. Full page reports of the initial New York Podiatry-Labor meeting were carried in The Machinist, published by the International Association of Machinists; Solidarity, the official United Automobile Workers paper; National Maritime Union's Pilot; and more than a dozen other publications of international and local unions.

Dr. Milton Werbel, President of the New York State Podiatry Society, in advising New York practitioners of the progress of the labor program, stated, "Programs have been established with three separate international unions covering a membership of well over one hundred fifty thousand in this State. We can be certain that

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thousands of people never before exposed to foot care and podiatry, will receive a thorough indoctrination."

The Labor Committee, headed by Dr. Ernest Weiner and Dr. Benjamin Kauth, along with Mr. Gilbert Hollander, Executive Secretary for the Podiatry Society, has made necessary arrangements to hold foot examinations in cooperation with three major unions in the state. In addition, a controlled study has been established involving several hundred union members working on the New York waterfront to check the incidence of fungus infection and to study methods for ending this occupational hazard.

OHIO

Ohio Re-registration Law Clarified

The recently passed Ohio law calling for annual re-licensure of all chiropodists holding Ohio licenses has raised a number of questions about procedures. This may answer some of those questions.

Every chiropodist holding an Ohio license and practicing in Ohio is required to complete two days of postgraduate study annually, certify to the Ohio State Medical Board that this requirement has been fulfilled and pay a registration fee of $5.00 in order to maintain the license. Deadline is June 1, 1960.

Any chiropodist practicing outside of Ohio, but holding and desiring to continue to hold his Ohio license must also re-register annually and pay the $5.00 registration fee. Chiropodists *not* practicing in Ohio are *not* required to take the postgraduate work.

The Ohio State Medical Board will supply all known Ohio license holders with re-registration forms annually. It must be pointed out that the Medical Board does not have up-to-date addresses and the burden of supplying the correct address is on the licensee.

It is, therefore, incumbent upon every licensee not a member of the Ohio Chiropodists Association, to send his correct address either to the Ohio State Medical Board, 21 West Broad Street, Columbus, or preferably to the Ohio Chiropodists Association, 50 West Broad Street, Columbus, Ohio. The Ohio Association will keep every licensee on record informed about

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Little Johnny Sorefoot

changes in the law, its interpretations and postgraduate courses to be offered.

In order that every man practicing in Ohio have sufficient opportunity to get his two days of annual postgraduate work prior to June 1, 1960 the Ohio Association is sponsoring courses at the Ohio College of Chiropody, December 5-6, 1959; Ohio State University Medical Center, March 19-20, 1960; and the annual convention, May 20-21 at the Sheraton-Gibson Hotel in Cincinnati. Registration forms will be available on all courses. Members as well as non-members of the Association are eligible for all courses sponsored by the Association. Fees for members will be lower than for non-members by virtue of the fact that through their regular dues, members are already paying for the administration of the courses.

The Board of Directors of the Ohio Association has also approved numerous other scientific courses given across the country when the courses are (1) of two days duration, (2) are sponsored by the American Podiatry Association or one of its affiliates (state association) two day scientific courses sponsored by any College of Chiropody or any approved section of the APA. Attendance at the scientific sessions of the A.P.A. will also be approved as soon as registration procedures can be set up. Attendance at the August, 1959 meeting of the A.P.A. will *not* qualify a licensee for registration in 1959-60 year inasmuch as the annual meeting of the A.P.A. and the effective date of the Ohio law were almost coincidental and no procedures had been established for certification.

The new Ohio law has brought many interesting points to light. Among these is the idea that a license to practice chiropody, once granted by a state, may not be taken away or hedged with certain restrictions.

It is of importance to point out that any license is issued by a governmental body for the purpose of protecting the health, welfare and safety of the citizens of the governmental unit issuing the license. A license is a privilege only in the sense that

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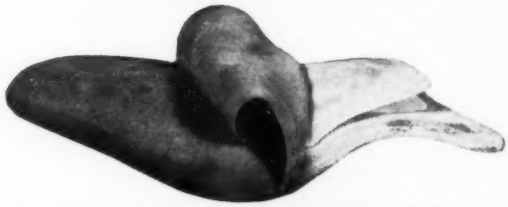

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it excludes those not licensed from illegally entering into competition with those licensed. But, it is a privilege which the state can remove or restrict.

The new Ohio law removed chiropodists from a so-called "limited practice" statute and placed chiropody in the framework of the general medical statutes of the State. It gave a chiropodist the legal right to be called "surgeon." It gave him the right to use antibiotics, analgesics and anesthetics. He may operate on the foot in any manner, although he may not use general anesthesia. He may write prescriptions and prescribe drugs. About the only thing he may not do is treat systemic diseases. He may treat the diabetic lesions, but not the diabetes. Although the Ohio Chiropodists Association office secured almost universal payment of insurance claims (including Blue Shield, Aid for Aged and Industrial Commission) prior to the passage of the Ohio law, the Association believes that the law will help, particularly where surgery is involved.

There is only one area of telephone directory advertising in Ohio and the new law provides that all directory advertising be the same type, size and color and a license may be revoked for fraudulent advertising. The Association has taken cognizance of certain ads that emphasize "relief of pain" and will, in all probability, take action to determine the extent to which these representations are fraudulent and refer them to County Prosecutors for action.

Of interest to the orthopedic man is the section of the new law which defines "the making of molds or casts of the foot," as the practice of chiropody. In reverse, this simply means that laymen may not make and prescribe molds or casts for foot problems unless done under the supervision of the chiropodist.

The Ohio Association believes that the re-registration section of its new law is the most forward, strongest step the Association has taken in its attempt to improve the professional level of chiropody. It is true that "you can lead a horse to water."

OUR NEWEST MOULD

The Levy Latex Mould and Contour Inlay made completely of Latex and Sponge Rubber.

After many years of intense research and the cooperation of a prominent Doctor and Competitor, we have at long last succeeded in fulfilling the idea originated by Dr. Ben Levy TO CUSHION THE FOOT.

This product constructed of Sponge and Latex Rubber is far superior in comfort to any so-called space shoe, and, very important to our woman to-day, in no way mars the beauty of the shoe.

We strongly recommend it for those suffering from Arthritis, Circulatory or Diabetic conditions. Also for bony, rigid and sensitive feet as well as for Verruca, Ulcers and Scar Tissues. It also is made in an inlay type without crest.

The ORIGINAL CONTOUR is retained at all times.

A negative or positive Cast at right angle is necessary.

LEVY & RAPPEL, INC.
384 Columbus Ave., New York 24, N. Y.

Whether he drinks or not is open to question, but it is the belief in Ohio that professional men are fundamentally interested by the progress and techniques of their profession even though they may not have made, especially, efforts in the past to acquaint themselves with the new techniques or to stay abreast of the progress.

The fact that 287 Ohio chiropodists attended the recent postgraduate course sponsored by the Association and given at the Ohio College of Chiropody, reveals that interest can be kindled. There are only 480 chiropodists in the State. In 1960 the Association plans to offer three courses in general chiropody plus a special course in Industrial Chiropody which will be given at the Ohio State University Medical Center and taught by the Industrial Medical Staff of the University as well as by selected chiropodists who are especially skilled in Industrial Chiropody. Attendance will be limited.

SOUTH DAKOTA

At the recent meeting of the South Dakota Association of Chiropodists-Podiatrists, the following officers were elected: President, M. D. Scofield of Sioux Falls; Vice President, Fred Rule of Sioux Falls and Secretary-Treasurer, F. W. Unzicker of Mitchell.

ILLINOIS

A new chiropody endorsement, which may be added to the basic Blue Shield program, is now being offered by the Blue Shield Plan of Illinois Medical Service to firms which have the basic Blue Shield program. This special endorsement has been developed in cooperation with the Illinois Chiropody-Podiatry Society, as part of the Plan's continuing policy of keeping pace with members' needs and today's growing specialization in different fields.

When a firm adds this endorsement to the basic Blue Shield certificate, all employees of the firm will be enrolled under the endorsement for a very small charge in addition to their regular Blue Shield dues. Then, when an enrolled member receives

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CHICAGO 14, ILL.

surgical services from a licensed podiatrist-chiropodist, Blue Shield will pay the same allowances for his specialized surgical services on the foot as it would pay to physicians, according to the Schedule of Allowances in the Blue Shield certificate for foot surgery.

The schedule of allowances is broad, but does not include under this special endorsement routine treatment or removal of corns, callouses, or the trimming or other partial removing of toenails.

Dr. L. C. Numbers, Insurance Chairman of the Illinois Chiropody-Podiatry Society, congratulated Blue Shield on its recognition of the growing importance of the professional services of the podiatrist-chiropodist in the field of foot surgery, stating:

"We are very happy to see Blue Shield take this step forward in enlarging the scope of its services to members which in the past have been limited to physicians licensed to practice medicine in all its branches. The Blue Shield Plan of Illinois Medical Service is one of the first plans in the country to take this action and we welcome its cooperation in making it possible for us to serve its members."

CIVIC HOSPITAL

On December 12, 1959, the Staff of Civic Hospital of Detroit, Michigan, met at its annual residents banquet. Dr. Marvin Shapiro, featured speaker for the evening, spoke on "Reflections in Pedic-Medicine." A plaque was presented to Earl Kaplan, D.S.C., in honor of his successful work in promoting a better understanding of foot surgery in the profession. Meyer Berk, D.S.C., President of the Staff, presented the annual awards to the following residents who completed their training at Civic Hospital in 1959: Drs. Richard Lanham, Jr., of Indiana, Seymour Beizer of Florida, Allen Fine of Kentucky and Bernard Hersh of Ohio. Following the formal program, Dr. Shapiro entertained the Staff with reminiscences of his recent European tour.

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Chicago, Illinois

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OHIO COLLEGE OF CHIROPODY

Dr. B. C. Egerter, President of the Ohio College of Chiropody at Cleveland, Ohio, has named Dr. Raymond K. Locke of Englewood, New Jersey, Director of Research at the college. Dr. Locke will work directly with foundations and corporations concerning research projects and grants. Up to the present time, Dr. Locke has served in the capacity of Consultant in the Department of Research. He also has served on many occasions as a guest lecturer at the college.

Dr. Locke attended Indiana University and is a graduate of the Ohio College of Chiropody. He is a member of the American Podiatry Association, having served on its Executive Council and as Chairman of its Medical Public Relations Committee. He is also a member of the New Jersey Chiropodists' Society, the American Society of Chiropodical Roentgenology, the American Podiatry Council and is on the staff at the Associated Physicians of Hackensack Hospital.

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ILLINOIS ALUMNI EDUCATION FOUNDATION

Representatives of the Alumni Education Foundation of the Illinois College of Chiropody and Foot Surgery recently presented a check for one thousand dollars to officials of the college.

This check symbolizes the nation-wide campaign now being conducted among the alumni and friends for the college to help expand foot health education and research.

The check was presented to Dr. Wheeler, President of the Illinois College of Chiropody and Foot Surgery, and Dr. Donald V. Anderson, Dean, by Dr. Philip R. Brachman, Chairman for Illinois and member of the Board of Directors of the Alumni Education Foundation, and Dr. Henri DuVries, Chairman of the Department of Surgery at the school and an organizer of the Foundation.

The Foundation expects to complete shortly the first of its fund-raising campaigns by reaching the $25,000.00 mark which will make it eligible to receive a proffered grant of $10,000.00.

AMERICAN ASSOCIATION OF HOSPITAL PODIATRISTS

The American Association of Hospital Podiatrists is established with the idea of working in closer harmony with the American Podiatry Association (as a component part of the American Podiatry Association) and with the American Medical Association. Its purposes are: (1) To help establish and maintain harmony and broader understanding between the Podiatrist, the Hospital and the Medical Doctor. (2) To aid hospitals seeking Podiatrists on their staff, by acting as a screening board, with the help of the state and local organization, and to recommend qualified Podiatrists for these positions. (3) To further the interest of Podiatrists in hospital matters, to broaden privileges, to improve status, to increase the scope of hospital practice and other objectives necessary to

the growth of our Podiatry profession. (4) To insure the best Podiatric care of all patients admitted to the hospital or treated in the Out-Patient Departments. (5) To provide a means whereby problems of a Podiatric and administrative nature may be discussed between the Medical and Podiatric staff. (6) To provide the Podiatrist with improved standards of hospital care and education. (7) To serve as an Information Bureau on all questions pertaining to Hospital Podiatry.

Those interested in becoming a member of the American Association of Hospital Podiatrists will request the necessary information from Dr. H. Charles Lilienfeld, Secretary, American Association of Hospital Podiatrists, 101 West 57th Street, New York 19, New York.

"A cynic has no influence and a pessimist no friends."

Raymond Moley in Newsweek

LEGAL AND LEGISLATIVE

PENNSYLVANIA

By amendment to the Workmen's Compensation Act, signed into law December 28, 1959, Pennsylvania chiropodists are authorized to receive payment under this act.

Also signed into law on the same date was another amendment, one under which chiropodists are a recognized authority for medical excuses for children.

"We hold that the same law of righteousness should obtain between nation and nation as between man and man."

Theodore Roosevelt

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CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Chicago, Ill., Aug. 27-30, 1960
Drake Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Hartford, Conn., Oct. 21-23, 1960
Statler Hilton Hotel
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
New York, N. Y., Feb. 19-21, 1960
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Philadelphia, Pa., May 5-8, 1960
Sheraton Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Mid-West Conference
Chicago, Ill., Mar. 25-27, 1960
Morrison Hotel
Dr. Ralph M. Ticko, Pres.
536 W. Wisconsin Ave., Milwaukee, Wis.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Omaha, Neb., April 1-3, 1960
Sheraton-Fontenelle Hotel
Drs. Harold G. Wieseman and Ken C. Nielsen
640 City Natl. Bank Bldg., Omaha, Neb.

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)
Sun Valley, Idaho, Sept. 7-11, 1960
Challenger Inn
Gordon R. Tobin, Convention Chairman
153 Third Ave., North, Twin Falls, Idaho

Region Eight
(D. C., N. C., S. C., Va., W. Va.)

Region Nine
(Florida)
Dr. E. B. Hurd, Gen. Chairman
623 DuPont Blg., Miami, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Atlanta, Ga., Oct. 7-9, 1960
Dinkler Plaza Hotel
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E., Atlanta, Ga.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Southwestern Chiropody Congress
Oklahoma City, Okla., June 20-23, 1960
Skirvin Hotel
S. D. Tomlinson, Gen. Chairman
3101 Classen Blvd., Oklahoma City, Okla.

Region Twelve
(Ariz., Cal., Nev., Utah)
Western Podiatry Congress
Long Beach, Calif., May 27-28, 1960
Lafayette Hotel
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

Canadian Podiatry Association
Dr. L. Hurwitz, Exec. Sec.
3017 Bathurst St., Toronto, Ont.

New Mexico Podiatry Society
Dr. Leon Cohen, Program Chairman
306 N. Canal St., Carlsbad, N. Mex.

Attend Your

STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

IN AUGUST 1960

IN CHICAGO, ILLINOIS

MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.
A.O.P.

A few chuckles

The lady driver: "Can you fix this fender so my husband won't notice the dent?"

Mechanic: No Ma'am, but I can fix it so you can ask him in a few days how HE dented it."

Ain't it the Truth?

An auction sale is a sale where you get something for nodding."

One reason that children brighten up the house is that they never turn out the lights.

You may not know when you are well off but believe me, the Internal Revenue Bureau does.

DR. POD By Bob Hughes, D.S.C.

If you don't stop fooling with those prosthetics we'll never get to the Andrews party—Charles!

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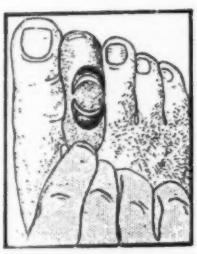

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"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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Advertisements not exceeding 30 words cost $3.00. Additional words 10 cents each.

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Please do not ask for the names of classified advertisers in the JOURNAL who use box numbers. We accept such advertisements with the understanding that this information will not be released. Address replies or inquiries to the box number shown in the advertisement. They are promptly forwarded to the advertiser.

WANTED: Exhibits on any chiropodial or related subject. To be shown at the Region 12 Convention. For details write to Dr. Simon M. Lane, 8234 East Third Street, Downey, California.

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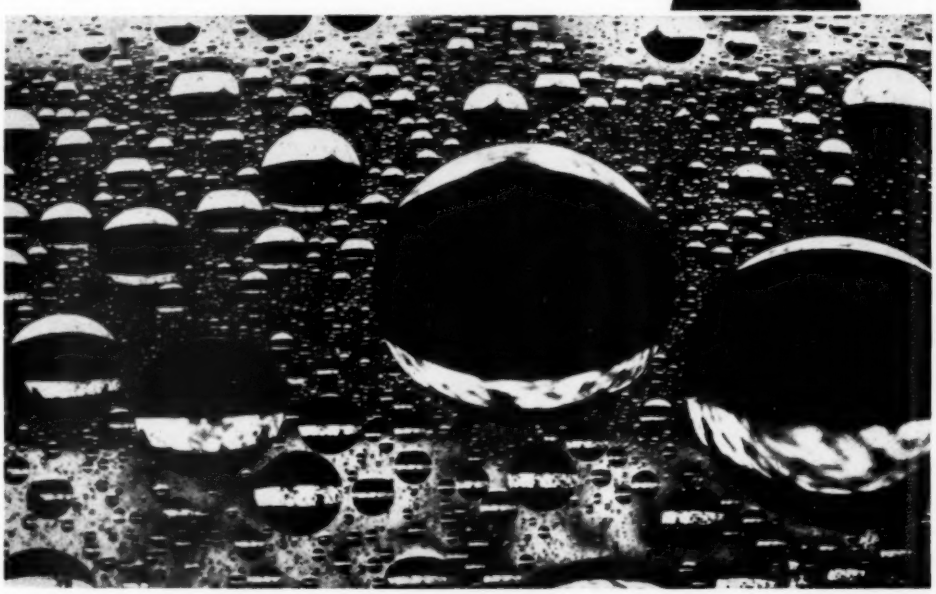

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